DOCUMENT RESUME

ED 379 882 EC 303 756

AUTHOR	Eggbeer, Linda, Ed.; Fenichel, Emily, Ed.
TITLE	Educating and Supporting the Infant/Family Work Force: Models, Methods and Materials.
INSTITUTION	Zero to Three/National Center for Clinical Infant Programs, Arlington, VA.
REPORT NO	ISSN-0736-8083
PUB DATE	Jan 95
NOTE	75p.
AVAILABLE FROM	Zero to Three, National Center for Clinical Infant Programs, 2000 14th Street North, Suite 380, Arlington, VA 22201-2500.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Zero to Three; v15 n3 spec iss Dec 1994-Jan 1995
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Curriculum; Developmental Disabilities; *Disabilities; *Early Intervention; Educational Methods; Family Involvement; Family Role; Infants; Interpersonal Relationship; *Professional Development; *Teacher Role; *Teaching Models; Toddlers; Training Methods; Videotape Recordings

ABSTRACT

This special newsletter issue was based on a July 1994 forum for educators and trainers of infant/family practitioners. Papers in the first section present emerging conceptual frameworks and the process of helping trainees to use these frameworks. Included are the following papers: "Head Start: The Emotional Foundations of School Readiness as Challenge, Lens and Language for Training" (Abbey Griffin); "Diagnostic Thinking about Mental Health and Developmental Disorders in Infancy and Early Childhood: A Core Skill for Infant/Family Professionals" (Robert J. Harmon); and "Mediated Learning, Developmental Level, and Individual Differences: Guides for Observation and Intervention" (Pnina S. Klein and Serena Wieder). The essays in the second section focus on the centrality of relationships to early development and the need for constant interweaving of content and process in training. Included are: "On Supervision" (Jeree H. Pawl); "Teaching Family-Centered Skills through the Case Method of Instruction" (P. J. McWilliam); and "Parallel Processes" (Karen C. Mikus et al.). The third section addresses directly the role of the trainer in the following papers: "Reflecting on the Art of Teaching" (G. Gordon Williamson); "Using Relationship To Teach Relationship: The Risky Business of Role Playing" (Rebecca Shahmoon Shanok et al.); "New Roles for Parents" (Evelyn Hausselin); and "Learning Together: A Parent's Perspective" (Pat Hughson). The final section presents an annotated listing of 15 curricula for infant/family training and 52 videotapes for training. (Most papers contain references.) (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 379 882

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it
☐ Minor changes have been made to improve reproduction quality
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

ZERO TO THREE
National Center for Clinical Infant Programs

Volume 15 · No. 3 · December 1994/January 1995 ISSN 0736-8083

SPECIAL ISSUE

Educating and Supporting the Infant/Family Work Force:

Models, methods and materials

Linda Eggbeer and Emily Fenichel, editors

BEST COPY AVAILABLE

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Emily Fenichel
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Educating and Supporting the Infant/Family Work Force: Models, Methods and Materials

A special issue of ***Zero to Three***
December, 1994/January, 1995

LINDA EGGBEER and EMILY FENICHEL, *editors*

---

3 Introduction

New Frameworks of Knowledge for Trainers

5 Heart Start: The Emotional Foundations of School Readiness as Challenge, Lens and Language for Training
Abbey Griffin

11 Diagnostic Thinking about Mental Health and Developmental Disorders in Infancy and Early Childhood: A core skill for infant/family professionals
Robert J. Harmon

16 Mediated Learning, Developmental Level, and Individual Differences: Guides for observation and intervention
Pnina S. Klein and Serena Wieder

Relationship-based Learning

21 On Supervision Jeree H. Pawl

30 Teaching Family-Centered Skills through the Case Method of Instruction
P.J. McWilliam

35 Parallel Processes Karen C. Mikus, Rita Benn, Deborah Weatherston

Learning through Teaching

41 Reflecting on the Art of Teaching G. Gordon Williamson

46 Using Relationship To Teach Relationship: The risky business of role playing Rebecca Shahmoon Shanok, with Linda Eggbeer and Emily Fenichel

53 New Roles for Parents Evelyn Hausselin

55 Learning Together: A parent's perspective Pat Hughson

Materials for Infant/Family Training

58 Curricula for Infant/Family Training

61 Videotapes for Training

Copyright © 1995

ZERO TO THREE/National Center for Clinical Infant Programs

2000 14th Street North, Suite 380

Arlington, Virginia 22201-2500

(703) 528-4300, fax (703) 528-6848

Publications orders: 1-800-899-4301

Design: Susan Lehmann

Production Coordination: Joan Melner

ZERO TO THREE/National Center for Clinical Infant Programs is the only national non-profit organization dedicated solely to improving the chances for healthy physical, cognitive, and social development of infants, toddlers, and their families.

Established in 1977, **ZERO TO THREE** is committed to:

- exercising leadership in communicating the importance of the first three years of life;
- focusing attention on the quality of infants' and toddlers' major relationships and on children's day-to-day experiences within these relationships;
- developing a broader understanding of how services for infants, toddlers, and their families are to be provided; and
- promoting training in keeping with that understanding.

Board of Directors

Kathryn E. Barnard, University of Washington

T. Berry Brazelton, Children's Hospital Medical Center, Boston

Maria D. Chavez, Children, Youth, and Family Department, State of New Mexico,

Robert N. Emde, University of Colorado School of Medicine

Linda Gilkerson, Erikson Institute, Chicago

Stanley I. Greenspan, George Washington University School of Medicine

Robert J. Harmon, University of Colorado Health Sciences Center

Irving B. Harris, Pittway Corporation, Chicago

Asa Grant Hilliard III, Georgia State University, Atlanta

Gloria Johnson-Powell, Harvard Medical School

Sheila B. Kamerman, Columbia University School of Social Work

Anneliese F. Korner, Stanford University School of Medicine

J. Ronald Lally, Far West Laboratory, San Francisco

Bernard Levy, New York City

Alicia F. Lieberman, University of California, San Francisco

Samuel J. Meisels, University of Michigan

Dolores G. Norton, University of Chicago

Robert A. Nover, George Washington University School of Medicine

Joy D. Osofsky, Louisiana State University Medical Center, New Orleans

Jeree H. Pawl, University of California, San Francisco

Deborah A. Phillips, National Research Council, Washington, D.C.

Kyle Pruett, Yale University School of Medicine

Arnold J. Sameroff, University of Michigan

Marilyn M. Segal, Nova University, Fort Lauderdale

Rebecca Shahmoon Shanok, Jewish Board of Family & Children's Services, New York

Jack P. Shonkoff, Brandeis University, Waltham Massachusetts

Lynn Straus, Mamaroneck, NY

Ann P. Turnbull, Beach Center on Families and Disability, Lawrence, KS

Bernice Weissbourd, Family Focus, Inc., Chicago

Serena Wieder, Clinical Psychologist, Silver Spring, MD

G. Gordon Williamson, JFK Medical Center, Edison, NJ

Barry Zuckerman, Boston University School of Medicine

Forum Planning Committee

Linda Gilkerson, Chair

Robert J. Harmon

Ann P. Turnbull

Serena Wieder

Introduction

Educating and Supporting the Infant/Family Work Force is a special issue of *Zero to Three*. It is the product of Zero to Three's July, 1994 Forum for Educators and Trainers of Infant/Family Practitioners. Led by Linda Gilkerson, Ph.D., ZERO TO THREE convened the Forum to offer experienced preservice teachers and inservice trainers in the infant/family field an opportunity to: share their successful training approaches and materials; discuss candidly the perplexing training challenges that face all disciplines and service settings involved with infants, toddlers, and their families; "take time out" to reflect on their own teaching and to learn about new content; and explore possibilities for new infant/family training initiatives at the local, state, regional, and national level.

More than 150 educators and trainers attended the Forum in Washington, D.C. About two-thirds of the group were involved primarily in inservice training and one-third primarily in preservice training. Participants came from 30 states, represented all disciplines serving infants, toddlers, and their families, and worked in Head Start, child care, family support, infant mental health, early intervention, and child welfare settings.

Generous support from a private foundation has allowed us to work with Forum participants to translate their creative, thoughtful presentations and dialogues into the document you are about to read.

The four sections of this publication reflect issues and concerns identified in a survey of Forum participants and readers of *TASKTalk*, ZERO TO THREE's newsletter on training. The contributions to the first section, **New Frameworks of Knowledge for Trainers**, illustrate our field's continuing quest for new conceptual "lenses" through which to view more clearly the complexities of development during the earliest years of life. Survey respondents identified infant/toddler development, infant/family observation and assessment, and intervention techniques as the content areas most central to training for work with infants, toddlers, and their families. The essays in this section present emerging conceptual frameworks and also explore the process of helping trainees learn to **use** new conceptual frameworks. Abbey Griffin reviews the message of ZERO TO THREE's *Heart Start: The Emotional Foundations of School Readiness* and discusses the use of *Heart Start's* perspective as a common language in interactive training. Robert J. Harmon uses ZERO TO THREE's *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)* as the basis for a discussion of diagnostic thinking—a core skill for infant/family professionals in any disciplines. Pnina Klein and Serena Wieder describe the complementary perspectives on parent/infant interaction offered by two new theoretical frameworks—mediated learning experience theory and developmental/ structuralist theory.

The essays in the second section, **Relationship-based Learning**, recognize that the centrality of relationships to early development (and to all infant/family work)

demands a constant interweaving of content and process in training. Survey respondents identified ongoing supervision and mentorship as the second most critical training issue in the infant/family field ("money and resources" came first). As trainers, respondents prefer to do hands-on training, with staff participation and demonstration; small-group, interactive training; and supervision.In their essays on supervision, the case method of instruction, and parallel processes, Jeree Pawl, P.J. McWilliam, and Karen Mikus, Rita Benn, and Deborah Weatherston address these themes and validate these approaches. They describe respectful, reflective, supportive training **relationships**—relationships that enable practitioners to engage in the respectful, reflective, and supportive endeavor known as family-centered care.

The contributions in the third section, **Learning through Teaching**, illustrate the adage, "The best way to learn something is to teach it." As teachers, survey respondents were looking for innovative training approaches, worried about maintaining trainees' interest and enthusiasm, and felt that they wanted help in learning new training techniques and adapting material for different educational levels and backgrounds. In this section, Gordon Williamson, Rebecca Shahmoon Shanok, Evelyn Hausslein, and Pat Hughson describe, with generous candor, the sometimes anxiety-producing, occasionally exhilarating, and always demanding business of taking on the role of teacher.

The fourth section, **Materials for Infant/Family Training**, reflects the creativity and resourcefulness of participants in the Forum for Educators and Trainers, who brought to Washington and shared with each other a rich treasure of class assignments, training exercises, reading lists, videos and detailed curricula. Although we cannot capture in print the passionate "shop talk" of the Forum, we provide, as examples, information on some of the training curricula shared at the Forum. The descriptions of videos for training have been compiled by Margie Wagner, who participated in the Forum and organized the video theater at ZERO TO THREE's 1994 National Training Institute. This listing is inevitably incomplete—we know that more good infant/family training videos exist and are being produced daily—but it does suggest the many sources our field can tap for powerful training materials.

Educating and Supporting the Infant/Family Work Force: Models, Methods, and Materials is designed to offer teachers and learners at every stage of professional development in the infant/family field some resources to use today, some ideas to reflect upon over time, and, we hope, some inspiration to join the dialogue. We want to learn about (and, together, to find new ways to share) the models, methods, and materials you have developed as trainers; your personal experiences as learners and teachers; and your concerns about (and challenges to) current ways of training. Please write, fax, or call us at ZERO TO THREE, so that together we can learn better ways of supporting the development of infants, toddlers, and their families.

Linda Eggbeer and Emily Fenichel

1

Heart Start: The Emotional Foundations of School Readiness as Challenge, Lens and Language for Training

Abbey Griffin

Heart Start: The emotional foundations of school readiness (ZERO TO THREE, 1992) presents a challenge to parents, educators, and early care and education professionals, particularly those concerned with school readiness. It asks fundamental questions: What does it really mean to be ready to learn? Aren't children born ready and eager? What happens to their "readiness" in the first years of life? What experiences in the earliest years of life provide children with a foundation for successful learning, in school and throughout life? What reinforces infants' sense of themselves as learners, problem-solvers, thinkers, and competent social beings who can perceive and abide by the rules of the school setting or workplace and can respond to the challenges of being a good spouse, good parent and good neighbor? Meeting this challenge, invites thinking about the continuum of learning that begins at birth. *Heart Start* frames school readiness issues in terms of both biological and environmental contributors to the development of each child's full potential.

Heart Start is not a program or a curriculum. It is a presentation of ideas about human characteristics associated with learning and the circumstances that make critical learning experiences possible. The power of *Heart Start* is the simplicity of its message. It offers a common lens and language that can be used for many audiences and for many purposes. Communities and statewide organizations in Vermont, Florida, Utah, Texas, California, Massachusetts, Illinois and New York are using *Heart Start* as a lens through which to examine the quality of their infant/family services, as the focus of public awareness campaigns, and as a framework for developing strategies to address areas of identified need.

Increasingly, ZERO TO THREE staff have been testing *Heart Start's* potential for use in training front-line service providers, planners, administrators, trainers and supervisors in the field of early care and education. A new grant from the Ford Foundation will support the creation of *Heart Start* training materials. This article describes how we have used *Heart Start* in one- and two-day training sessions. What we have to offer is a work in progress, a mutual learning process in which participants are invited to explore the power and importance of intense, meaningful early relationships through stories, discussions, and development of strategies for translating *Heart Start*'s ideas into personal and programmatic change.

Heart Start—A lens, a language, not a curriculum

Heart Start offers a lens through which to view early development and a common language with which to share what we see through that lens. *Heart Start* argues that a young child's knowledge of how to learn

Abbey Griffin, Ph.D.
ZERO TO THREE/National Center for Clinical Infant Programs, Arlington, Virginia

and his development of seven characteristics related to learning are much more significant than the number of words in the child's vocabulary or her ability to identify colors or letters. This premise is simple and often persuasive, but it is challenging to apply. If training based on *Heart Start*'s perspective is to be integrated into practice, a trainer and a group of trainees need to engage actively with *Heart Start*'s ideas, expanding, challenging, and refining their thinking together.

Not surprisingly, we have discovered that messages about the importance of intense, meaningful early relationships are best conveyed by inviting learners to reflect on and share their own stories, and by joining with them to begin a process of planned change.

We have found it useful to plan *Heart Start* training sessions around three tasks. The first task involves exploration and definition of the seven characteristics associated with learning that are described in *Heart Start*. The second task involves discussion of health, unhurried time, responsive caregiving, and a safe, supportive environment as critical supports for young children's development. The third task involves structured action planning around ways to put *Heart Start*'s ideas into action in participants' own workplace or community. Facilitators use concepts and case examples to invite participants to reflect deeply on their own life experiences as well as on their work with young children and families.

Task One: Discussing the seven characteristics

What are the characteristics, developed in the first three years of life, that underlie our ability to learn and our commitment to learning? The seven characteristics are:

1. Confidence: A sense of control and mastery of one's body, behavior and world; the child's sense that he is more likely than not to succeed at what he undertakes, and that adults will be helpful.

2. Curiosity: The sense that finding out about things is positive and leads to pleasure.

3. Intentionality: The wish and capacity to have an impact, and to act upon that with persistence.This is clearly related to a sense of competence, of being effective.

4. Self-control: The ability to modulate and control one's own actions in age-appropriate ways; a sense of inner control.

5. Relatedness: The ability to engage with others based on the sense of being understood by and understanding others.

6. Capacity to communicate: The wish and ability to exchange ideas,feelings and concepts with others. This is related to a sense of trust in others and of pleasure in engaging with others, including adults.

7. Cooperativeness: The ability to balance one's own needs with those of others in a group activity.

Presenting these characteristics to a group tends to evoke nods of recognition and agreement. But a trainer or facilitator must often work hard to encourage a group really to think about each characteristic—defining, describing, arguing, negotiating among different interpretations, analyzing case examples, and finally building a consensus around a definition for each term.

This process is necessary preparation for the group's development of a common lens and language to use as it goes on to consider its own practice. Self-reflective exercises, group discussions, and the sharing of stories have all been successful strategies for building a shared sense of meaning. For example, one powerful exercise involves asking participants in a training session to explore the internal model for learning developed in their earliest years and modified over time. What is their approach to new challenges: Are they generally confident? Do they pursue a new task with a sense of intentionality? Are they likely to use others as resources to master a task? Exploring who we are now invites us to think about how we developed from our earliest years and what we carry into our adult lives.

Group discussion or brainstorming can help develop a shared definition of each of the seven characteristics. The facilitator introduces each term and asks for synonyms or short descriptive phrases. Differences of opinion often arise and lead to greater clarity. For example, in a workshop with a diverse group of highly trained and experi-

enced infant and toddler specialists, an argument developed about whether intentionality, self-control and cooperativeness were conflicting.

Specifically, the question was: can children be persistent and desire to have an impact and, at the same time, modulate their actions and balance their own needs with those of others? Some participants equated "intentionality" with willful determination, which, if taken to the extreme, would lead to conflicts and uncooperative behavior if a child's activity were disrupted by others. The group eventually agreed that intentionality reflects the capacity to make choices, be persistent in pursuing an interest or mastering a task, be willing to experiment, and be able to use help from others when needed. To be effective as a learner and competent as a social being, a child or adult needs inner control in order to handle the challenges of the task and cooperativeness if that task involves working with others.

An illustration of a young child's behavior can help a group move from a conceptual discussion to a shared experience of "seeing through a new lens." In the discussion of intentionality, self-control, and cooperativeness, a participant offered this vignette:

Janice (11 months) was given a cardboard tube and a ball and was fascinated with first the tube, then the ball. She hit the floor with the tube, then put the tube down. She reached for the ball, put it in her mouth, and then let it fall to the ground. As she crawled after the ball, she held the tube in her hand. For days her experimenting continued. Sometimes either the ball or the tube was taken from her by other babies, and when that happened she watched, as if looking to see if the other baby would do something interesting with the object. She was clearly pleased with her explorations. One day, she put the ball into the tube and, watching it come out the other end, she shrieked with surprise and pure joy.

Analyzing this story allowed the group to explore the use of the characteristics in observing and interpreting children's behavior. Janice clearly demonstrated intentionality in her interest and exploration of these new objects. She was persistent over time and expressed the joys of both experimentation and mastery. When other babies played with either object, she watched, which suggests an ability to learn by observing others and, perhaps to control her impulse to possess what was of such interest to her.

Her story also gave the trainer an opportunity to ask what would have happened if on the first day, the caregiver had directed Janice in how to get the ball through the tube? How much would Janice have learned about the capacities of each object? Would Janice have grown in confidence, curiosity, or intentionality?

Sometimes participants use a story to connect one of the characteristics to their current situation. As the capacity for cooperation and communication was discussed in a training session involving supervisors and new practitioners, a supervisee made the following personal observation:

The supervisory relationship requires cooperation. Cooperation involves a balancing of one's own needs with those of the other (in this case the supervisor). If I am the kind of person who always wants to please and has trouble asking questions because I think people will see me as a complainer, or making my needs clear because people might see me as a whiner, then I will make it hard for my supervisor to help me develop professionally.

As trainers, we are careful to generalize from a personal statement so that everyone can share in discussing the example. In this case, generalization came naturally. As this participant moved us from observations of the child to reflections on professional relationship, the group seemed to share a spontaneous and simultaneous "aha!"—early experiences do have a continuing impact.

Activities that invite participants to explore the meaning of the seven learning-related characteristics and the ways in which these characteristics develop are very important for infant/toddler practitioners at all levels of education and experience. Inviting stories about ourselves and the children we have worked with helps to not only define the terms but to hone observation skills. Analyzing videotapes and case studies allows participants to become more adept at

observing through the Heart Start lens. For example, we have used two instructional components of the Program for Infant and Toddler Caregivers (1990, 1991, 1992, 1993). The videotape and trainer's guide for *The Ages of Infancy* offers general overview of early development suitable for audiences with limited education or experience. *Flexible, Fearful, and Feisty* offers excellent opportunities to observe the expression of different temperaments.

Task Two: Discussing basic supports for young children's development

Once participants have defined, through discussion, the seven characteristics associated with young children's learning and feel able to identify these characteristics through observation, a training session can move on to discuss the four sets of supports described by *Heart Start* as essential to the healthy development of young children. These are:

1. Assuring health: Health supervision, immunization, early detection and treatment of disease, early identification of special needs and requisite diagnostic assessment and treatment, and adult knowledge of health promotion.

2. Time for unhurried caring: Time for parents and caregivers to observe, care for and interact with each infant; time for child care providers to get to know the family as well as the individual routines, temperament and changing interests and skills of each infant; time for parents to adjust emotionally to parenthood and/or the transition to work and/or to special needs their baby may have.

3. Responsive caregiving: Warm, loving, supportive relationships with adults who understand child development, are alert to differences of temperament, biological rhythms, rates of development, special challenges and individual styles of communication and who individualize caregiving so that the infant can feel understood and valued.

4. A safe and supportive environment: Protection from causes of injury, including violence; adequate income; decent housing; adequate space and a safe, attractive, challenging environment for the growing infant and toddler to explore.

In our training sessions, we link these supports to the developmental challenges of the first three years. However, while discussion of the seven characteristics associated with children's successful learning tends to elicit feelings about participants' own early experiences and generates stories and observations, discussion of the basic needs of young children and their families often leads practitioners and trainers to talk about the ways in which their own "professional basic needs" remain unmet. Management problems,large case loads, inadequate salaries and benefits, scarce opportunities for training and consultation, and general lack of resources are themes frequently raised.

We know that participants who come to a Heart Start training session want information on early development and the needs and resources available to support families. We also recognize participants' need to identify the realities of their profession and their workplace and to vent—and validate—their feelings. A discussion of participants' own needs seems to clear the air in a workshop or training session, so that creative energy is mobilized.

Again, participants' own experiences make concepts come alive. A child care provider told this story:

I had Sarah from the time she was 10 weeks old. I thought her parents were great and communication between us was always easy. They were very young and didn't have much money, so I helped them out by caring for Sarah on the weekends and overnight sometimes. I started seeing bruises on the mother. Sarah started acting differently—sometimes really quiet, sometimes she wouldn't let me go. I never saw the dad after that and Sarah's mom wouldn't tell me what was happening. She just wanted me to take Sarah more often. I knew I had to do something. I didn't want to tell her "no" because I was afraid of what was going on at home. I called Child Protective Services but they said I didn't have enough evidence and that I should talk to the parents first. I didn't know how to get the mother to talk to me. Who

could I call for help? Where was I going to tell her to go for help?

This caregiver's story raised a number of important themes, involving her own needs for professional boundaries and support as well as the needs of Sarah and her family. The family child care provider is particularly susceptible to sacrificing her income and time with her own family to meet the needs of the families she cares for. The infant and family's unmet needs for health care, unhurried time, responsive caregiving, and a safe environment were painfully clear to this caregiver. But she had not been trained to counsel parents nor did she feel competent even to raise such a delicate issue with the mother. She was sensitive to Sarah's changed behavior but lacked formal assessment skills. She felt shut out by the protective services system and did not know where else to get help for herself or the family.

Personal stories are powerful, often emotional, and they may present a real challenge to the trainer, who must organize what was said into some positive options. In this case, discussion had focused around two main themes. The first was the need for clear management policies and their role in building strong, mutually respectful relationships between parent and caregiver. The second was each of the basic needs of the child and the primary responsibility of both parent and caregiver to meet those needs. The group concluded that only when both parent and caregiver clearly understand and appreciate both themes can they can join as partners in finding appropriate community resources. Research summaries and resource information can help participants in a training session appreciate the complexity of young children's needs. Handouts to participants provide this information in a useful format.

We also use observation of videotapes and reflection exercises as a way to engage participants in the material and visualize it in their daily practice. The Program for Infant and Toddler Caregivers' video, *Not Just Routines*, challenges participants to think about the time they spend with infants and toddlers. How much time is spent in diapering, handwashing, food preparation, feeding, and cleaning? How could interaction during caregiving routines be made more "unhurried" and "responsive" to the individual needs, interests, and personality of each child? *Spaces To Grow*, another video in the same series, encourages thinking about the role of environments in making it possible for caregivers to protect child health, provide a safe and exciting environment, be responsive and have unhurried time with individual children. Teaching Strategies' *Creative Curriculum* (1990) also promotes discussion of planning and managing space. For example, with well planned, easily accessible storage space—and plenty of it—caregivers spend less time looking for things and more time with children.

Task Three: Structured action planning

ZERO TO THREE's first "live" presentations of *Heart Start*'s ideas and recommendations were to advocacy and planning groups. They had read *Heart Start* and wanted to use its framework to assess the adequacy of their communities' supports for families with infants and toddlers and to plan strategies to address unmet needs. We developed an action planning chart to use in workshops in order to record: 1) ideas for ways to use *Heart Start* (generated through brainstorming); 2) one or two ideas identified as priorities for action; 3) a list of skills and resources needed to accomplish desired changes; and 4) timelines and assigned responsibilities.

We have maintained action planning as a core element of any Heart Start workshop, even if the purpose of the session is "training" rather than community organization or advocacy skill-building. We have found that the challenge of planning strategies for accomplishing change helps participants to translate *Heart Start*'s concepts into the language of their daily work. For example, early care and education professionals who are eager to use the seven characteristics associated with children's learning as desired outcomes (replacing an emphasis on isolated skills, such as recognition of colors) may need to review their child observation tools, their training materials, and

their communications with parents. Trying to achieve "unhurried time" for one-to-one relationships between caregivers and children involves a hard look at staff assignment and time management policies. In the course of structured action planning, practitioners from any discipline or infant/family service setting (or from a mix of backgrounds) are likely to identify community, state, or national policies that support or impede *Heart Start* goals. This awareness can encourage service providers to expand their notion of professional responsibility to include policy development and implementation.

It is a challenge for facilitators to help a group move from a common understanding of *Heart Start*'s perspective to identification of barriers to change and, finally, to action planning. It is exhilarating to see a group develop consensus around one or a few carefully considered objectives for an action agenda. Trainers always want to see whether and how content is translated into practice. While it is not possible to go to work with every participant, the action planning component offers a glimpse at how participants intend to incorporate the principles of *Heart Start* into their work.

In closing

ZERO TO THREE looks forward to exploring the potential of *Heart Start* as a training tool for those in field of early care and education. We hope that the materials we develop will help those who plan, train, supervise and provide direct care for infants and toddlers see the richness of intense, meaningful early relationships. We hope to be joined in a broad dialogue around what it really means to be ready to learn and the important role of caring, knowledgeable adults joining with families in providing the essential foundation for each child to reach his/her full potential.

References

California Department of Education and Far West Laboratory for Educational Research and Development (1990, 1991, 1992, 1993) *Program for Infant/Toddler Caregivers*. Sacramento, CA: California Department of Educatjon.

Teaching Strategies, Inc. (1990). *The Creative Curriculum*.Washington, DC. Author.

ZERO TO THREE/National Center for Clinical Infant Programs (1992). *Heart Start: The Emotional Foundations of School Readiness*. Arlington, VA: Author.

2

Diagnostic Thinking about Mental Health and Developmental Disorders in Infancy and Early Childhood: A core skill for infant/family professionals

Robert J. Harmon

Researchers, practitioners, and families have learned a tremendous amount in recent years about emotional, intellectual, motor, and sensory patterns in infancy as well as the types of challenges that can interfere with optimal development. We are becoming better able to create or restore favorable conditions for healthy development. However, gaining the comprehensive understanding of a child's and family's circumstances needed to formulate an effective, preventively oriented treatment approach is not an easy task. It is harder to accomplish with very young children than with older children and adults for several reasons. First, although each child and family is different, infants' and toddlers' "distress signals" often look very similar. Second, since development proceeds so rapidly during the first three years of life and multiple lines of development are so interrelated, a number of observations over time are needed in order to distinguish a "vicissitude of normal development" from a pattern that may become a chronic problem. Most importantly, infants and young children need to be understood in context—in their relationships to their families, to their communities, and to their culture.

A comprehensive framework for diagnosing emotional and developmental problems in the first three years of life is offered by *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)*, a new publication from ZERO TO THREE/National Center for Clinical Infant Programs. The product of an eight-year effort by a multidisciplinary Diagnostic Classification Task Force of clinicians and researchers, *DC: 0-3* is designed to focus attention on all key aspects of young children's experience—the infant's relationships with caregivers; individual differences in motor, sensory, language, cognitive, and emotional development; the young child's capacity to organize experience; family patterns; and psychosocial stressors in the environment as they affect the infant or young child. The *DC: 0-3* framework includes five "axes": 1) primary diagnosis; 2) relationship disorder classification; 3) medical and developmental disorders and conditions; 4) psychosocial stressors; and 5) functional emotional developmental level. Using this framework, an individual or team is able to collect and integrate information on: the nature of the infant's or child's difficulties and strengths; the level of the child's overall adaptive capacity; and level of functioning in the major areas of development, including social-emotional, relationships, cognitive, language, sensory and motor abilities in comparison to age-expected developmental

Robert J. Harmon, M.D., Professor and Head, Division of Child Psychiatry; Director, Kempe Center Therapeutic Preschool, University of Colorado Health Sciences Center, Denver, Colorado

patterns; the relative contribution of different areas assessed (family relationships, interactive patterns, constitutional-maturational patterns, stress, etc.) to the child's difficulties and competencies; and a comprehensive treatment or preventive intervention plan.

"Diagnostic thinking" may go by various names in different disciplines, but it should be a cornerstone of all professional work with infants, toddlers, and their families. While this article draws primarily on my experiences in helping child psychiatry residents, clinical psychology fellows and interns, and other advanced trainees in mental health disciplines develop their diagnostic skills, the training strategies and issues described are relevant to all disciplines.

Why do we need to teach diagnostic classification?

Teaching trainees and practicing professionals to use a common system of diagnostic classification will advance the new field of infant mental health and early intervention in three important ways:

1. Professionals and parents will be able to talk the same language as they share observations and experiences. A common vocabulary is essential to the development of a new field of inquiry. Cross-training among disciplines and training for reliability are important to ensure that individuals who use a term mean the same thing when they use it.

2. A common system of diagnostic classification builds a foundation for research, broadly defined. Once professionals are able to agree on diagnostic formulations, they can begin to compare treatment recommendations and look at treatment outcomes. Do teams in different settings and different parts of the country recommend similar or different interventions for children with similar diagnostic profiles? What are the impacts of different types of intervention? Are we making a difference?

3. Standard diagnostic criteria are useful in expanding and improving services for families. In current and emerging systems of health care, services are linked to diagnoses. Standard diagnostic criteria are important not only for reimbursement for services, but also in the design and development of service programs.

Diagnostic classification does have some potentially negative consequences, which must be taken seriously in both training and practice. Both families and professionals worry that some diagnoses tend to lead to stigmatization and "blaming the victim." We also worry about "self-fulfilling prophecies," especially if a diagnosis has been associated traditionally with poor outcomes. These very legitimate concerns reinforce the importance of training infant/family professionals in a process of diagnostic thinking. The major contribution of *DC: 0-3*, in my opinion, is that following its five axes forces an individual or team to undertake a comprehensive, systemic approach to understanding each child seen. The diagnostic profile resulting from such a process identifies both strengths and vulnerabilities in all major developmental areas, caregiving relationships, and psychosocial environments affecting this child. And most importantly, the diagnostic profile is designed to guide treatment planning.

Using *DC: 0-3* in the Division of Child Psychiatry at the University of Colorado

The University of Colorado has a tradition of excellence in infant and toddler development, dating back to René Spitz's pioneering identification of hospitalism and anaclitic depression among institutionalized infants 50 years ago. Some researchers at Colorado, including Robert Emde, Louis Sander, and myself, have focused on the ontogeny of emotional development, affective regulation, moral and cognitive-motivational development, and the importance of relationships and attachments in the early years. More recently we have examined the risk and protective factors in 'clinical' populations, including both children and parents who have biological, psychological or social risk factors. Still, with contributions to the understanding of mental health and developmental disorders of infancy and early childhood now coming from so many

disciplines and theoretical perspectives, the comprehensive *DC: 0-3* framework helps to expand the thinking of our trainees and our faculty. For example, our department tends to attract people with strong backgrounds in assessing the ways in which parents' life histories may contribute to their current relationships with their children. Yet, they may not be as experienced in considering what the infant brings to the relationship—temperamental, constitutional, sensory integration, "within-child" issues. Trainees sometimes wish for simple answers, but we insist that they "embrace complexity." Diagnosis involves thinking about: 1) the family; 2) the child; 3) the culture and context, and 4) what has happened that brought them to the clinic.

Broadening perspectives and teaching diagnostic skills takes time. In our program, 12-14 child psychiatry residents as well as doctoral and post-doctoral students in clinical psychology spend two years in infant clinic, meeting 48 times each year. Six or seven of the sessions each year are didactic. The rest are clinically based case presentations, often including videos. During these case presentations, we ask: What are we thinking about diagnostically? What are we seeing developmentally? What are the trainees' specific observations and questions? What is the best treatment or preventive intervention plan?

To introduce *DC: 0-3*, I give an hour-long overview of the diagnostic system in infant clinic, explaining the various primary diagnoses, reviewing the guidelines for selecting the appropriate diagnosis, and using case vignettes to illustrate all diagnostic axes. The next week, I ask each trainee to think about his or her most recent or most vivid case and to use the *DC: 0-3* 11-page data collection form[1] to record information about the child and the caregiving environment, information from the assessment of the child, using a multi-axial diagnostic formulation from the *DC: 0-3* classifications, and treatment modalities recommended and/or implemented. No one (including me) has ever fallen in love with the data form at first sight, but it does force one to cover all areas included for a comprehensive assessment. Our trainees are required to fill out a data form for every child who is seen for an evaluation, which typically involves at least 3-4 sessions. The form becomes part of every infant clinic chart and needs to be filled out for the medical record to be complete. Thus, our trainees cannot "graduate" unless they have completed a form on all of their infant cases.

Of course, the data form is not an end in itself, nor is formulating a diagnosis a one-time event. What we are trying to teach is the process of diagnostic thinking. Gaps in our information suggest things to look and listen for as we work with a child and family—Have I forgotten to ask about a family history of affect disorders? What can I really say about this parent? Does the child have regulatory problems?

We also teach the process of differential diagnosis—that is, considering a cluster of presenting problems and concerns as well as ranking possible diagnoses from most likely to least likely. In other words, is a rumble from the back of your car always a signal of a problem with bearings or brakes?

Could the sound come from the forgotten watermelon rolling in the trunk? Differential diagnosis involves asking, "What could this be?" In Colorado, the sound of hoofbeats probably comes from horses, maybe from buffalo, or possibly from zebras. Using *DC: 0-3*, a clinician consulted, for example, about an infant or toddler's sleep problems would try to identify possible underlying causes (such as an anxiety disorder, a relationship disturbance, transient adjustment problems, traumatic stress disorder, or regulatory disorders) before making a diagnosis of sleep behavior disorder. By forcing yourself to consider all of the relevant reasons for a sleep problem in this infant within this family, one is less likely to overlook more serious, underlying disorders by simply, and conveniently, calling it a "sleep

Trainees sometimes wish for simple answers, but we insist that they "embrace complexity."

[1]This data collection form is part of the research efforts of the Diagnostic Classification Task Force (see page 18 of *DC: 0-3*). It is designed to allow experienced infant clinicians and trainees under supervision to organize the information collected during the assessment and is helpful in ensuring that a comprehensive assessment is completed. Those wishing to use the form should contact Serena Wieder at ZERO TO THREE.

Some psychiatrists still do not believe that the caregiving environment is very important in determining "mental health" outcome.

problem." An integrated treatment plan then follows more easily from a careful diagnostic formulation.

Learning to formulate a diagnosis and to translate this formulation into an intervention approach takes time and support. In our infant clinic, senior professionals, many of whom have been working with infants, toddlers, and families for 15 years, screen referrals before assigning a trainee as the evaluator/therapist. Even though our residents and interns are highly trained mental health professionals, we do not assume that they know what to do once the assignment is made. For example, they may not know how to play with very young children. If a trainee is assigned to work with a child and family and does not know how to proceed, he or she first brings the case to infant clinic, and we discuss appropriate ways to assess the presenting problems, including when to meet, how to begin the session, how to structure the sessions, and what toys to use.

One first-year child psychiatry fellow came to clinic with a crisis on his hands. An 18-month-old child had been kicked out of his child care center for biting. The center would not let the child back in without a note from the doctor. What should be the approach? Five trainees had five different ideas about what might be going on. But this was no time for leisurely theorizing—the family was in crisis. We quickly arranged a meeting with the parents and shortly thereafter with the parents and the child. The clinician learned that the parents were experiencing severe marital problems and that the child was regressing developmentally. With this information, our group understood this child's aggression as something very different from, for example, the aggressive behavior of a child with a history of early and chronic physical abuse. This treatment focused on helping the parents with the marital discord and easing its effect on their toddler, while reassuring the child care center that this was a transient problem amenable to therapeutic interventions.

With support from professional "parents" in the form of individual supervision as well as infant clinic group discussions, trainees find themselves learning more quickly as they go on. Luckily for me, over the last 15 years, our child psychiatry residents have rated the infant clinic as one of the strongest components of their training, and our emphasis on infant mental health has been a major training recruitment asset.

Introducing *DC: 0-3* in other child psychiatry settings

Trainees who come to the University of Colorado's Division of Child Psychiatry know that we are very interested in children from birth to age 5 and approach our work from a developmental perspective. Other training programs in child psychiatry may be quite skeptical about the notion that very young children have diagnosable mental health problems, or even the idea that the earliest years of life are important. In these settings, I have often found a lack of appreciation for the impact of trauma and of inadequate, inappropriate, abusive parenting. Some psychiatrists still do not believe that the caregiving environment is very important in determining "mental health" outcome. (Of course, geneticists themselves recognize the importance of genetic/environmental interaction. Our challenge as therapists is to find ways to ameliorate the environment.)

Recently, support from the Abramson Fund of the American Academy of Child and Adolescent Psychiatry allowed several experienced child psychiatrists to provide consultation to help other child psychiatry training programs strengthen their training in infant mental health. In the consultations assigned to me, I first spoke to the whole department of psychiatry (in "grand rounds") about our new research on the development of children of depressed mothers. Next, I would speak to 50-150 people in "child rounds" about the *DC: 0-3* framework. Finally, I would meet with a smaller group to discuss specific infant/preschool clinical cases. With participants in all these forums, I explored possibilities for connections with clinical and other services within the medical center (for example, NICUs and specialty clinics for young children) and in the community (for example, well child clinics, child care, Head Start, and early intervention pro-

grams). We talked about opportunities for systems consultation, identifying community settings where mental health trainees can work and learn. One phenomenon that I am always concerned about is a special clinic designed to treat "Problem X"—a child may come in with "Problem Y," but by the time she leaves the clinic, she has often been diagnosed with and treated for "Problem X." A comprehensive, systemic approach to diagnosis reduces the chances of this kind of inappropriate assessment and intervention.

In these consultations and in other presentations in mental health settings, I have found faculty and trainees welcoming DC: 0-3 as a way to increase discussions about mental health and developmental problems of very young children. This, of course, is exactly what the ZERO TO THREE Diagnostic Classification Task Force has been working to accomplish—offering to people who want to provide mental health services for younger children the conceptual framework and common vocabulary they need to exchange ideas, document needs, and evaluate treatment approaches.

Diagnostic thinking in other infant/family training and service settings

Diagnosis can be described as the process of examining what is known about all relevant aspects of a child's circumstances, choosing the formulation which best fits the information, developing an appropriate plan for further monitoring or intervention, and reviewing the formulation as more information becomes available during the intervention process. Given this description, diagnostic thinking should be part of the repertoire of every parent and every practitioner who works with infants, toddlers, and their families. We try, for example, to help new parents wonder about the possible meanings of their baby's cries, so that they can learn to read cues accurately and respond appropriately. The late Sally Provence said that when hiring child care providers, she looked for intellectual curiosity as well as warmth; the competent caregiver tries to understand young children's behavior, not simply to manage it. As more and more people are working with infants, toddlers, and their families in a whole range of programs, interest in very young children's emotional development, mental health, and relationships is rapidly increasing. We need to build on this interest and awareness to ensure that diagnostic thinking remains focused on strengths and protective factors as well as on symptoms and vulnerabilities, and to make sure that appropriate intervention is the goal of any evaluation. In this context, it is important to recognize that, as a framework to guide comprehensive evaluation and treatment planning (which can occur in many different settings), *DC: 0-3* is designed for use by experienced infant clinicians and trainees under supervision. Gaining an understanding of how an infant or toddler is developing in all areas of functioning in the family context usually requires a number of sessions and expertise from several sources. Integrating assessment findings into a cohesive formulation is a skill in itself, and critical to the process of intervention planning. The ZERO TO THREE Diagnostic Classification Task Force recommends that settings strong in only some areas of assessment and intervention should obtain additional expertise through engaging additional staff or consultation, or through training existing staff. In this way, a variety of settings may be able to conduct truly comprehensive approaches to assessment and intervention with infants and young children.

Reference

ZERO TO THREE/National Center for Clinical Infant Programs (1994). *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. Arlington, VA: Author.

3

Mediated Learning, Developmental Level, and Individual Differences: Guides for observation and intervention

Pnina S. Klein and Serena Wieder

This article includes excerpts from a plenary address by Drs. Klein and Wieder at ZERO TO THREE's July, 1994 Forum for Educators and Trainers, an article by Dr. Klein, "More Intelligent and Sensitive Child (MISC): A New Look at an Old Question," *International Journal of Cognitive Education and Mediated Learning*, Vol. 2, No.2, 1992, and an article by Dr. Wieder and Stanley Greenspan, "An Integration of Developmental-Structuralist and Mediated Learning Experience (MLE) Approaches to Learning," *International Journal of Cognitive Education and Mediated Learning*, Vol. 2, No. 3, 1992.

Careful observation of children's development forms the foundation of all work designed to help infants and toddlers benefit from learning opportunities in their environment. In recent years, we and our colleagues have paid particularly close attention to three aspects of development in the earliest years: 1) caregiver-child relationships as the context for learning; 2) the way a child organizes experience according to his developmental level; and 3) the individually different ways each child uses his sensory processing and motor capacities to engage in an organized experience. This article presents an overview of Mediated Learning Experience (MLE) and Developmental-Structuralist models. Each model makes different variables more explicit, using its own lens to focus on critical phenomena. Together, the models' complementary perspectives offer an integrated guide to observation and intervention.

Perspectives from Mediated Learning Experience

Mediated learning—as distinct from direct learning through the senses—occurs when someone interprets the environment for the learner. Reuven Feuerstein and his colleagues who developed mediating learning experience (MLE) theory (1979, 1980) formulated a model of interactive learning that emphasizes the central role of relationships in helping a child understand his world. Feuerstein suggested that in a process of reciprocal interaction between a child and a mediator, the mediator (typically a parent) interposes herself between the child and the world by modifying the stimuli or the experience that the child will have. MLE theory argues that when parents and others who understand a child's needs, interests, and capacities take an active role in making components of the child's environment compatible with the child's current level of understanding, and in connecting current experiences to the past and future, their mediation increases the child's capacity to learn from new experiences.

Empirical studies in Israel, Norway, Sri Lanka, and the United States (Klein, Wieder, and Greenspan, 1987; Klein, 1988; Klein and Alony, 1993) have identified five basic elements that constitute a teaching me-

Pnina S. Klein, Ph.D., Bar Ilan University, Ramat-Gan, Israel

Serena Wieder, Ph.D., Clinical Psychologist, Silver Spring, Maryland

diational interaction between a caregiver and a child of any age. These factors are:

• **Focusing (intentionality and reciprocity):** An adult tries to change a child's perception or response by selecting, exaggerating, accentuating, scheduling, grouping, sequencing, or pacing stimuli. The adult knows what she wants the child to pay attention to ("Poison ivy has three shiny leaves"). Focusing enhances the child's need to see things in the environment clearly—an important skill for future learning.

• **Affecting (mediation of meaning):** Few things in the world have intrinsic meaning. While children may be predisposed to seek meaning and excitement in their experiences, adults typically endow the world with meaning, sharing with a child their own appreciation of the beauty and significance of the world verbally or non-verbally ("This book belonged to your grandfather; it is very special to me.")

• **Expanding (transcendence):** The adult broadens the child's cognitive awareness beyond what is necessary to satisfy the immediate need which triggered the interaction. The caregiver catches the child's attention, holds it, and makes connections to other objects or ideas, linking and connecting past, present, and future experiences ("You're right—that is a cat. He looks like our cat Stormy, doesn't he? Did you give Stormy breakfast this morning? Will you give him supper when we get home?") Experiences of expanding develop in the child a predisposition to seek associations and connections between his or her experiences.

• **Rewarding (mediated feelings of competence):** The adult expresses satisfaction with a child's behavior, verbally or non-verbally, or identifies specific components of the child's behavior which the adult considers successful. For the child, it is important that someone who sees development comments on it and identifies what led to success ("I like the way you figured out how to get the ball in the cup by sliding it under the lid.") Rewarding affects a child's self-esteem and appetite to experience more successes.

• **Mediated regulation of behavior:** The caregiver promotes learning how to do things and approaches such as planning, reflective thinking, and systematic searching as the basis for new learning ("Touch it gently; it may break." "First we take off the boots, and then..." Do the cookies look baked enough? I think they could use another minute. What do you think now?")

Expanding and rewarding are the two elements of mediated learning that are the most predictive of children's success in school. When mothers learn to change their mediational styles and methods, these changes seem to be sustained over time, become internalized, and are transferred to other areas of life.

Perspectives from Developmental-Structuralist theory

MLE theory draws the observer's attention to the interactive features of learning. Developmental-Structuralist theory (Greenspan, 1979; 1989; 1992) highlight two other features of learning necessary to a general model. One feature is the way the child organizes experience according to his developmental level. For example, the behavioral and gestural way an eight-month-old organizes experience is quite different from the representational-symbolic approach of a two-and-a-half-year-old.

The other element is the individually different ways each child uses his sensory, processing, and motor capacities to deal with experience. For example, a child who is overly sensitive to sound, or who finds it hard to hold in mind a sequence of sounds, will learn about and organize experience of her world differently than her counterpart with a great "ear" for sounds. She may depend more on what she sees and on moving about to learn, putting together actions and words more slowly. For her, mediation would require more looking and hands-on experimenting to support verbal discussion.

The seven developmental levels identified in the Developmental-Structuralist model are:

1. Mutual attention (all ages): Capacity to show interest in the world by looking and listening when talked to or provided with appropriate visual, auditory, movement and tactile experiences.

2. Mutual engagement (readily observable between 3-6 months): Ability for joint emotional involvement, seen in looking, joyful smiling and laughing, synchronous arm and leg movements, and other gestures which convey a sense of pleasure and affective engagement.

3. Interactive intentionality and reciprocity (readily observable between 6 and 8 months): Ability to interact in a purposeful, intentional and reciprocal manner, both initiating and responding to the other's signals.

4. Representational/affective communication (infants over 18 months): Capacity to use mental representations, as evidenced in language or pretend play, for communicating emotional themes and ideas.

5. Representational elaboration (children over 30 months): Capacity to elaborate, in both make-believe and symbolic communication, a number of ideas that go beyond the basic needs and simple themes typical of early representational communication above.

6. Representational differentiation I (children over 36 months): Capacity to deal with complex intentions, wishes and feelings in pretend play or other types of symbolic communication which involves two or more ideas which are logically connected.

7. Representational differentiation II (children over 42 months): Capacity for elaborating complex pretend play and symbolic communication dealing with complex intentions, wishes, or feelings.

Each developmental level involves different tasks or goals. Individual constitutional and maturational capacities include the child's: 1) sensory reactivity in each sensory modality (tactile, auditory, visual, vestibular, olfactory); 2) capacity to process (decode sequences, configurations, or abstract patterns) in each sensory modality; 3) ability to process and react to degrees of affective intensity in a stable manner; 4) motor tone; and 5) motor planning.

The developmental level and individual constitutional and maturational capacities of the child will have a great bearing on what occurs in a mediated learning experience. For example, an infant who is just beginning to form a relationship (engaging) may find it difficult to become deeply emotionally engaged with a mother who talks to him a great deal but doesn't hold him much. If, constitutionally, this infant has a slightly low motor tone and is hyposensitive with regard to touch and sound, his mother's intellectual and slightly aloof style may be doubly difficult for him, as neither she nor the child is able to effectively engage the other. At age three, the developmental phase and tasks are different. Now the task is no longer simply forming a relationship; it is now learning to symbolize (represent) experience and form categories and connections between units of experience. Now this same child may have an easier time (assuming that he received sufficient warmth from other caregivers to progress emotionally), even though his mother hasn't changed.

Because this intellectual mother is highly creative, enjoys pretend play as well as give-and-take logical discussions, and is no longer as worried about her son's dependency needs, she is more relaxed and quite available for play and conversation. Her verbal style is now meets the boy's developmental level and need for verbal interaction, since he is building his symbolic world and has matured so that earlier sensitivities do not impede his interaction. A better match exists between mother and child which supports their relationship and learning.

The goal of the Developmental-Structuralist model is to facilitate understanding of how all relevant factors influence the way a child organizes experiences. As a child's capacity to organize experience changes, new relationships evolve between the various family, constitutional-maturational, and interactional factors that in turn influence the child's growing organizing capacity. Particularly when infants and young children have atypical constitutional-maturational patterns, their parents' intuitive skills may not be sufficient to enable them to mediate the environment effectively. For example, first-time parents may not recognize that their child has difficulty taking in information from all their senses and that this is the reason the child "tunes out" or becomes disorganized when over-

whelmed by too much going on around them. An explicit understanding of the broader developmental tasks facing the child and the individual differences she evidences in relationship to these tasks may help parents and caregivers to foster learning.

Cultural and other variables that affect mediated learning experiences

In all cultures, adults mediate the environment for young children. But focusing, affecting, expanding, rewarding, and regulating behavior will look different in different contexts, depending on parents' values, assumptions and educational philosophy, child-rearing objectives, life experiences, and perceptions of the individual child.

What constitutes an ideal child (and consequently, parents' objectives for their children) differs dramatically across cultures. Consequently, objectives "imported" by child development experts from one culture may be unsuitable (and therefore stand little chance to be adopted) for parents of another culture. Working with parents and caregivers in Sri Lanka and Ethiopia, I (Klein) learned that parents do not value what they called a "Western type" of "pushy," self-centered, competitive, "intelligent" child. Their educational goal was to promote the development of a non-competitive, caring, sharing individual. In these cultures, parents might use "expanding" and "rewarding" behavior, but it would be directed toward a developmental outcome valued by the culture. For example, an expanding comment might be, "This song will help you go to sleep and have sweet dreams. My father sang it to me and his father sang it to him and when you have babies you will sing it to them." A rewarding comment might be, "Thank you for wiping Brother's nose just the way I showed you."

Mothers' perceptions of what "good mothering" should be and of themselves as effective agents in child development, their styles of coping with life stresses, their support systems, and their own knowledge of their environment and culture affect their mediation of the environment for their children. A mother's style of interaction with her baby is strongly affected by the model for parent/infant interaction that she holds (consciously and unconsciously) in her mind. Her own childhood experiences and memories of her relationship with her parents provide a filter through which she views and responds to the child's characteristics and behaviors. A mother 's knowledge about the environment (that is, her level of differentiation between trees, flowers, birds, animals, and objects and her acquaintance and appreciation of her culture's customs, songs, stories, and foods) will enhance or limit her capacity to develop her child's differentiated awareness of the world in which he lives and her ability to endow that world with meaning. If the parent does not focus on details in the environment or if they mean nothing to him, how is he going to point out or mediate these details for the child?

Culturally transmitted knowledge and beliefs, as well as individual feelings, affect the style and quality of mediation between a parent and an individual child. For example, western and traditional cultures have different beliefs about the timetable of infant development, and consequently about the appropriate timing to teach or encourage certain skills in the child or communicate in a certain way. (In Indonesia, mothers are embarrassed to be heard speaking to their infants, because, as they say, "People will think we are senseless speaking to a baby who cannot understand us." The belief that it is "senseless" to talk to a child who cannot talk back is not uncommon among young parents in the United States.) Independent of children's individual temperaments, parents tend to give boys more motor and physical stimulation and girls more visual and verbal stimulation (Klein, 1984). Parents whose culture views a child with a disability as a punishment from God that one has to accept are not expected to make any attempts to help the child reach optimal functioning. It is also possible that an adult may be a "good mediator" to one child but not to another, based on the adult's perception of the child and the child's perception of the adult.

A way of communicating or mediating

learning with the child can become stabilized into a relationship, during which the two participants invite particular styles of interaction from each other. For example, a Norwegian mother might sit behind her typically developing infant, quietly observing her play, because, like most Norwegian mothers, she believes that a child should be given freedom to choose what he wants to do without interference from an adult. Nevertheless, this mother might devise or be helped to develop a much more active style of mediation with a baby who seemed reluctant or unable to explore the environment on her own.

Translating observation into action

The ultimate purpose of observation, of course, is to guide efforts to help a young child adjust to our changing world, learn from new experiences, and become a caring, thoughtful human being. The perspectives on development offered by mediated learning experience and developmental-structuralist theory provide a framework for intervention by encouraging parents and professionals to focus simultaneously on each child's individual profile. What is to be expected for the child's current emotional and developmental stage? How can learning be mediated in the context of the child and family's environment and culture? MLE provides the strategies needed to help children learn successfully, while Developmental-Structuralist theory provides the understanding of individual differences and organizing elements needed to relate and integrate learning experiences.

With both of these perspectives, it is possible to move from observation to intervention with specific strategies and goals that address both current functioning and the underlying structure needed for success.

References

Feuerstein, R., Rand, Y., & Hoffman, M.B. (1979). *The dynamic assessment of retarded performers*. Baltimore: University Park Press.

Feuerstein, R., Rand, Y., Hoffman, M., & Miller, R. (1980). *Instrumental enrichment: Redevelopment of cognitive functions of retarded performers*. Baltimore, MD: University Park Press.

Klein, P.S. (1995). *Early Intervention: Cross-cultural experiences with a mediational approach*. NY: Garland Publishers, in press.

Klein, P.S. (1984). Behavior of Israeli mothers toward infants in relation to infants' perceived temperament. *Child Development*, 55, 1212-1218.

Klein, P.S. (1988). Stability and change in interaction of Israeli mothers and infants. *Infant Behavior and Development*, 11, 55-70.

Klein, P.S. and Alony, S. (1993). Immediate and sustained effects of maternal mediation behaviors in infancy. *Journal of Early Intervention*, (17) 2, 177-193.

Klein, P.S. and Hundeide, K. (1989). Training manual for the MISC (More Intelligent and Sensitive Child) program. Sri Lanka: UNICEF.

Klein, P.S., Wieder, S. and Greenspan, S.I. (1987). A theoretical overview and empirical study of mediated learning experience: Prediction of preschool performance from mother-infant interaction patterns. *Infant Mental Health Journal*, (8)2, 110-129.

4

On Supervision

Jeree H. Pawl

This essay is excerpted from a keynote address presented on January 21, 1994 at the Early Start Mentorship Symposium sponsored by the California Early Intervention Technical Assistance Network with California State University, Sacramento.

I have been a part of supervisory processes for about 40 years and I am beginning to get a sense of it. Professionally, I have always been involved in what in my field is called clinical supervision, either as a supervisee or a supervisor.

Because my first supervisory experiences in the field of clinical psychology were related to testing and I was supervised by those whose expertise was quite narrowly in that area, I have a very direct experience as to what it is like to be supervised in a rather technical, task-focused way. As I began to test, this is what I understood about what I was to do. I was to learn the test silly perfect in its verbal aspects, actually a superb idea, and I was to learn how to administer it flawlessly in its manipulative aspects - also a splendid thing. I was to learn how to score it properly and I was to learn how to write it up. How I was to get the child into the room, what I was to do once the child was actually standing in the room, what this rapport was that the test booklet and the supervisor told me I was to establish, were not discussed with me. I wondered—was I to rely on the obvious anxiety created in the child by the abrupt and incomprehensible separation from the parent and the subsequent closeting with a total stranger to result in cooperation? Was this rapport?

One supervisor, I remember, watched me administer a Stanford-Binet on an inpatient ward to a bedfast child and, having then corrected three words of my totally memorized administration and having pointed out that I incorrectly placed two pieces of the car puzzle, pronounced my administration, nonetheless, excellent.

Later, she was equally pleased with my scoring, the scoring consisting of judging whether or not a child's answer was right or wrong and correctly compiling areas of strength or weakness according to those scores. During the administration of that observed testing, I was so unbearably anxious that it is a miracle that I remembered anything about anything I had studied and memorized or that more pieces of puzzle did not slip out of my perspiring hands at the wrong time.

I remember that one supervisor tried very hard to teach me how to wedge a hyperactive child into a corner with the testing table and to be accompanyingly personally forceful and firm. Another tried to teach me how to pursue a child and test simultaneously under radiators and on top of desks. I was far better at the latter than at the former,—a really lousy trapper but an indefatigable, patient and tireless pursuer—though I was unsure what this "testing" could possibly represent that anyone might wish to know.

I could sequence analysis the very devil out of the Rorschach, but I wasn't really sure how I should be while I was giving it. None of my supervisors talked about any of that and I wasn't quite sure what I wanted to ask them or if I should reveal what must be only my discomfort, ignorance and yes—sense of fraudulence. I knew I didn't know what I was doing but I appeared to be fooling them. When were they going to find out and could I bear the charade in the meantime?

I remember testing one child who ceased having any successes on the Binet very quickly and whom I then needed to question relentlessly in order to comply with the

Jeree H. Pawl, Ph.D., Clinical Professor, Department of Psychiatry, University of California at San Francisco, Director, Infant-Parent Program, San Francisco General Hospital

BEST COPY AVAILABLE

Clinical supervision is a very special environment for teaching.

instructions—doggedly confronting the child with incomprehensible items until the required levels had been failed. Both of us got increasingly miserable but was I administering the test right or what?

Just as I was finishing torturing him, I realized that I was not being observed, so I dropped back several levels and began giving him items I knew he could pass. I even made some up. I was sure I would be drummed out of the corps if anyone knew—but he and I were both in a fine mood when I decided it was all right to quit. There was really no-one to tell except another student who thought it was a swell idea and adopted it.

Only when I began to do psychotherapy with children did my sense of what supervision could be begin to change, but I have never forgotten what it was like initially. No one helped me know how to be or to understand why it might be important to be in a particular way and no one was at all interested in my personal experience of what I was trying to do in this process of being with someone. No-one was really interested in the child's experience (as opposed to his performance) or certainly in mine. Gradually, as I was supervised in my clinical psychotherapeutic work and even more when I began to be a supervisor, I began to evolve the notion of what clinical supervision was, what its main purposes were and how one needed to be as a supervisor. Clinical supervision is a very special environment for teaching, created by the interaction between the supervisor and the supervisee. Just like any relationship, it always bears the stamp of each contributor and just like any relationship where one person bears greater responsibility than the other, the supervisor assumes the greater responsibility for the quality of what passes between them and for the basic parameters of the relationship.

It need not represent a power differential in terms of mutual acknowledgment and respect but it must, by virtue of the expertise and experience differential, acknowledge that the more experienced teacher bears greater responsibility than does the student for what transpires. In this relationship, the supervisor shares not only her expertise regarding the technical and skill challenges; she also contributes a crucial perspective concerning the power lodged in the relationship between the supervisee and the recipient of services. This is important because the relationship is, after all, the medium through which all services are given. This is true not only for psychotherapy but for recreational therapy, occupational therapy, speech and language, childcare and podiatry.

The degree to which it matters will vary enormously from absolutely central to only somewhat. But how one is in the situation is inextricably intertwined with what one does. Once a practitioner begins to know the truth of this she also begins to know that the service, whatever it is, is being delivered to a complex person who lives in a world in a complex set of relationships. Then the practitioner can begin to consider the implications of that. How one is with someone, how one treats someone—has an important impact which should not be overlooked.

Whether one actually attends to these things, is aware of them, values them, or cares a fig, they are influencing crucial outcomes. As a speech therapist, I may be primarily interested only in improving speech skills. But if I am, I need to understand the impact of how I am and how I go about that on the child with whom I work and on his mother and father. From every perspective, that matters, sometimes as much or more than what I am doing in regard to speech—whether I want it to or not. It's rather like transference in psychoanalytic theory. Analysts noticed it but they neither invented nor created it. It runs merrily or not so merrily quite rampantly throughout all of our relationships whether we care to credit it or not.

We need to focus on the profound impact simply of the practitioner's way of being. It is a crucial variable in the process. Improvement of speech in a child may be the goal but that outcome may be achieved as much by how the practitioner is with the child as what he actually does. Obviously, an improvement in speech affects the child's sense of himself and his impact on others but so does how one relates to the child. Thus, how one is, affects outcome both directly and indirectly in very complex ways.

The parents of the child, in their relationship with the practitioner involved, are simultaneously affected in many of these same ways so that unless one thinks of a nest of relationships cross-influencing one another, one misses appreciating the incredible power at all those levels that is influencing outcomes of all kinds.

A practitioner must understand this kind of influence in addition to understanding his work with particular people and his feelings about his work in order to develop as fully and effectively as possible. A place to do this most usefully is within a supervisory relationship. Of course, this adds another layer to the complexity. The supervisory relationship becomes a part of the nesting matrix as it influences the practitioner. I have coined a shorthand platinum rule to supplement the golden one in order to quickly convey a sense of this parallel process, "Do unto others as you would have others do unto others". This is an essential aspect of the supervisory relationship to appreciate. The relationship between supervisor and supervisee sets a major tone that verberates throughout the system, whether it does so for good or for ill. When it is positive, it can hasten exponentially the process of what the supervisee learns through experience and self-reflection. The practitioner's experience in supervision directly affect the interactions he has with the child and family. It is this complex nest of relationships we must care about.

When we think of it in the context of supervision we see how key supervision can be in its quality, its process and in its content. It is the concept of interlocking relationships that really links content and process. We have here, not a row of dominos but circles of dominos, the movement of any one of which at any moment affects the system in a notable way. Clinical supervision comes in many forms and shapes and may not always even be recognized by that name. It may happen over a cup of coffee - supervision on the fly. Something akin to it may happen in a kind of mini-form between, for example, providers of services, between a provider of services and the director or head teacher or an aide, and it may not be labeled as such though it may share some of its hallmarks. These hallmarks are frequently conceptualized as reflection, collaboration and regularity but they are only effective when they are nested in a relationship that is characterized by respect, mutuality and safety. A supervisory relationship without these qualities may teach some techniques and skills but has not reached the heart of what practitioners need to learn and experience to be most effective with their families. Supervision occurs in the environment of a work place and systems of relationships exist throughout that work place. The characteristics of attitudes and relationships that typify the leaders of an institution are felt throughout. Feelings flow both ways at every step and the tapestry of relationships of director-staff, staff-staff, secretary-staff and so on are the containers and carriers of the attitudes and feelings, and these flow up and down and across the system, often magnifying in the processes of transaction.

The program that I am with not only offers services to families but also offers mental health consultation to daycare -both center-based daycare and family daycare. In the course of doing our process evaluation, we looked at the relationship between problems described in the various centers on what we have imaginatively called our problem-goal forms and the quality of relationships between providers and children as reflected on our initial evaluation forms. These were filled out at the time of entry into the center and before there was any consultation. The programs with the most dismal relationships between providers and children had the following kinds of problems: There was an unclear flow of authority,—while at the same time there were markedly authoritarian methods of doing business with one another. Also, the relationships between staff and director and staff and staff were marked by a great deal of hostility, disrespect, and insensitivity. In such programs there were a number of cliques and a number of scapegoats. The most vulnerable of the scapegoats were the children who were either aimless wanderers or timed-out objectors to the culture of "ignore them" and/or "sit and shout at them from your chair." All of this is pre-

Do unto others as you would have others do unto others.

Even in well-functioning organizations, supervision is a protection against tense and difficult times.

dictable—but there it was in our process evaluation. Those providers who were treated the worst, treated the children the worst. This is a very costly parallel process. One thing that was noted on occasion was what one might think of as a "buffer supervisor." This referred to the fact that even when a system's basic attitude was negative and disrespectful and this negative influence was passed along the chain of command, occasionally there was a place in the hierarchial structure where there was a singular individual who changed the valence from negative to positive. Beyond this person the system functioned well in terms of reciprocity, respect and collaboration. Sometimes this person was a director of a small aspect of a larger system, or sometimes this person was a head teacher. Always, the person was remarkable in her ability to somehow absorb and deflect the negativity.

In those situations the relationships between providers and children were excellent. In fact, it seemed almost to be especially good, probably reflecting the unusual gifts, in terms of interpersonal skills and general attitudes, of this buffer supervisor. Without such buffer supervisors in a wretched and mean-spirited system, the line practitioner is buffeted by difficult feelings stemming from the experience within the organization and the complicated and sometimes conflictual feelings engendered by the family and the children with whom she works.

As one works to change systems, creating buffer zones may be a beginning and may protect some recipients of service. Determined peer supervisors or study groups or anything that will allow a few people to cohere in the spirit of collaboration may protect the work the organization is truly about and that's the point. Ultimately in such negative atmospheres the work will suffer and the point of the work is lost—or worse. In addition to everything else that it does, supervision can provide such buffer zones. Even in well-functioning organizations it is a protection against tense and difficult times.

Supervision exists to provide a respectful, understanding and thoughtful atmosphere where exchanges of information, thoughts and feelings about the things that arise around one's work can occur. The focus is on the families involved and on the experience of the supervisee. Depending on discipline, content may vary enormously, but it is not possible to work on behalf of human beings to try to help them without having powerful feelings aroused in yourself. At these times, process and content become one. In working with families who are in great difficulty, rage can become the most familiar affect,—at the system, at a world with too much violence that creates too much helplessness and also at a family who will not be better or even seem to try and then at yourself as an ineffective, incompetent, masochistic fool and who do you think you are anyway? And besides, your own system treats you like something ultimately very disposable.

Supervision is the place where all of these things belong, in addition to the specific discipline content. It is the place to understand the meaning of your work with a family and the meaning and impact of your relationship with the family.

A family with a child with a difficulty that troubles you particularly and with whom you cannot seem to find your balance—that belongs in supervision. Something about Arthur's mother that rubs you entirely the wrong way and you realize you really snapped at her very unpleasantly today—that belongs in supervision. In effect, one is examining one's practices and one's responses to one's work. One is also conceptualizing the underlying principles of that work from ever new perspectives and experiences over and over and over.

From a non-specific, non-discipline perspective, there are two major things that are the overarching concerns of every supervision. One, learning about your own view of people and the world, your biases, and your expectations. Two, appreciating that you will be the recipient of those same kinds of pre-formed expectations from others. Learning how to manage this is the work of supervision. It allows you to behave as you need to in order to understand others and to create experiences with them that are useful.

In the process of supervision itself, the

sets of expectations through which the world enters are automatically broadened for both supervisor and supervisee because two sets of sensitivities, knowledge and experience are now collaborating. The wonderful individual differences between all of us, guarantee no duplication of effort. With the additional differences of age, sex, culture, ethnicity, religion, fatness, prettiness, shyness, boldness, oldness, you name it, the participants in this process are guaranteed an extraordinarily rich experience of learning where each is an enhancing and sometimes corrective filter and lens for the other.

A male supervisee teaches me not only what he can because of who he uniquely is but also because he is a male. When there is not a racial or class match, then this provides a fruitful ground for mutually enriched learning and understanding on both sides. The many differences in experiences and natural styles of being between supervisor and supervisee enlarge the understanding of each participant. Differences in group memberships between supervisor and supervisee guarantee no specific contributions to understanding because of the filter that each individual provides to her membership experience. Still, they are individual experiences of very different worlds of meaning and understanding and this is very enriching. I have come to feel that people are simultaneously both more different than alike and more alike than different in almost every way I can think of.

Supervision is not intended to produce a clone of the supervisor. It is instead designed for the mutual discovery within the process of supervision of the relevant characteristics and skills of these unique supervisees. In the process, they will learn how best to use themselves in relationship to those to whom they will provide their services. It is through a process of understanding, discussion and self-reflection, interwoven with the understanding that some appropriate amount of theory, technique, practicality, or skill may bring that good outcomes are achieved. Any good supervisor learns to count on the supervisee's unique, appropriate responses to many things which occur in their work—responses that are different from those the supervisor would have had.

Supervision well done equally enlarges and teaches the supervisor. Not only in the ways just described, but also because the supervisor re-experiences her own professional growth and is very often markedly reinspired by the supervisee's enthusiasm for the work. The supervisee has the benefit of the supervisor's rekindled memories paralleling her experience. Those memories, freely shared, are of equally sound and useful efforts and sometimes equally useless treks down equally worn paths and with a mutual understanding of the reasons for such journeys. Many of the things that arise in the discussion are clear for the first time to the trainee and newly deepened for the supervisor. Others remain mysteries to both. Parenthetically, I must say, that I am not sure when it was that I began to think of myself as the Miss Marple of Supervision, (clearly to a fault), but I do know, that the same memory of an experience is not the same in the context of the new illumination of a particular trainee's individual light. I have learned that I can learn something new —quite new, about an old insight and that there is no experience with which one is ever done or has ever used up.

We seek in supervision to learn where our professionalism lies. I sometimes think that it is mostly unspoken anxiety that interferes with professional flexibility and generosity of spirit, as if a carefully constructed professional persona were somehow more important and more likely be valued than simple personhood—that qualities of ordinariness might make us seem and feel less important or that to be more like than unlike someone with whom we work might diminish us. Perhaps this over-professionalization is a singular problem in the field of traditional mental health. Despite the fact that being unprofessional is a present and distinct danger, being lost in a too rigid, somewhat artificial sense of what professionalism is seems equally dangerous.

In fact, we are professionals by virtue of our knowledge and expertise and part of that expertise needs to be learning "How to be." As the psychiatrist, Harry Stack Sullivan implied long ago, we ought to work toward the day when professional training

We seek in supervision to learn where our professionalism lies.

I don't think it is possible for any of us to do what we do without some good place to tell our tales.

does not need to be followed by a period of unlearning. Mental health professionals often bear the burden of needing to unlearn attitudes about how to be with a patient. Other professionals delivering highly skilled, but less amorphous services often seem instead to need to learn that their attitudes and relationships with those with whom they work matter profoundly. Both need to be continuously alert and continually learning about just what the parameters of those relationships should be—in general and in relationship to particular people. All of these things are the objects of reflection in supervision. It is a process that preserves sanity and good practice and preserves a stable staff. Both those with enormous natural gifts in understanding themselves and others and those without such gifts will need that safe space with someone where they can test the reality of their perceptions, express their feelings, get some confirmation and feel a sense of doing their job well. Personally, I value supervision very highly. I have preserved it at some cost to myself and to my staff in terms of time and energy. And although within my own place supervision is not only reflective and collaborative but regular and frequent I recognize that there must be many models for how one might achieve a good measure of what it is all about. But I don't think that it is possible for any of us to do what we do without some good place to tell our tales. I would like to spend some moments talking about what the barriers to supervision or mentorship, which ever comes first, might be in the fields of intervention which are not specifically in the area of formal mental health.

In some ways these barriers to the institution of clinical supervision seem to me self-evident but I'll talk about them anyway. Clinical supervision within formal mental health training occurs very naturally and automatically. That is because we have no concrete skills and cannot help with anything except the procurement of cheese and other comestibles and the expression and understanding of feelings. Therefore, we are forced to learn something about how people operate and how we should operate in relation to them in order to be at all helpful—or to cure them, or to make them behave right, or to overwhelm their oppositional resistances or to resist their devious manipulations or to find some strengths or to admire their determination or I'm sure you get the point. The goals of mental health with and without supervision as delivered by a wide variety of professionals are not necessarily either the same all the time or benign all the time. Supervision within mental health does not guarantee particular positive attitudes towards those with whom one works or toward oneself as a practitioner. Supervision designed to create stress can be considered awfully good for the soul and conceptualizing supervision as only the relentless analysis of countertransference by the supervisor can result in the trainee deciding it would be a duplication of effort to seek additional treatment when it's already being provided.

Nonetheless, clinical supervision in the mental health profession is a teaching method which does focus on process and interaction much of the time. And one does become very aware of oneself as a variable in the situation. This, as I said, obviously presents the major difference. As a childcare worker, an OT, a nutritionist, or a speech pathologist, it is the technical skill and personal learning experience in regard to the work that is the primary focus. The self as an instrument of influence is not the focus. When one shifts one's professional focus on the patient from his specific difficulty to his breadth of personhood and his context and to one's relationship with that patient and what it can tolerate, one has already created both a different self and more self-awareness as a practitioner. But this still leaves out the impact we have that is not purposeful,—all the considerations of self as a constant factor as well as all the other complexities I mentioned before. When it is suggested that some of this be included in the thinking about one's work, it is easy to imagine a certain ruffling of well-arranged and well-nurtured feathers. To wit, "I know what business I'm in and I chose to be in that business because that is what interested me." "I really don't appreciate somebody redesigning my profession." "I am in childcare partly because I'm not trained to do anything else,

but also because I like kids and that's enough." or "because I am an educator and I know curriculum and I know what children need in terms of learning." In this latter instance it may be unappreciated that the nursery school teacher of the past rarely exists and instead the child's caregivers share his world for 8, 10, or 12 hours a day, not two. The role that this substitute caregiver plays in a child's life and what this means in terms of how that caregiver needs to be may not have been at the heart of the matter in terms of that person's choice of profession. Understanding why a child behaves in a particular way can be irrelevant if you know that what you need to do is to control him or, if that's not possible, make it clear that he can no longer be in your daycare center. As for the parents, when they're rude and impossible, it's their problem, not yours.

Any time one tries to enlarge the vision of what someone else's job is, it is not likely to be embraced without some resistance unless the person has been earnestly seeking it, as some people do. A dear colleague of mine talks about how uncomfortable he was with what he felt happening between himself and some of the mothers of the children whom he was seeing early in his practice. He felt that things were going on that he didn't understand and he sought clinical supervision (not treatment you will notice) as a way of examining his work and his feelings about it. This is the extreme end of receptivity. It can be more a matter of "this was really not what I had in mind when I chose to focus on child development". It may turn out that by advocating supervision one is advocating including a focus on exactly what the professional's choice was designed to avoid.

I should make very clear that I'm not suggesting that these more ephemeral but vital aspects of the relationship would be the sole or even the central part of supervision for every professional working in intervention. They should be part of it, but they certainly do not need to be the sole focus. Just because they are the core of my own profession does not suggest to me that they have to be the core of any other. For those aspects to be ignored, however, is to distort in a negative way the services provided. A supervisor of an OT may well be another very experienced OT but that OT must be able to provide expertise not only of a most focused and practical kind but expertise that stems from having moved well along the road in understanding a great deal of the contexts and impacts of relationships and her own role in all of that. As the field of early intervention moves to a family focus this is impossible to avoid if one is to be at all effective.

Part of the resistance to accepting a broader vision and the need for a supervisory relationship may be that it feels like an imposition of mental health unto all of the other disciplines in early intervention. But, in fact, nobody owns mental health in the most important and general sense of it. And what does stem more specifically from mental health is only a way to understand how to think about and begin to manage many things with which one is being confronted already,—no matter what one's profession is, as well as a way of learning how to use personal impact in a positive way. This latter can only happen if one begins by appreciating its existence and then becomes determined to house the exploration of this phenomenon in a safe and useful place.

Although partnership with parents is unquestionably a natural and necessary way of conceptualizing and carrying through work with families, this does not eliminate the need to acknowledge very real and different skills and expertise that parents and professional bring to the effort. In fact, the recognition of this differential can, it seems to me, more genuinely enhance and promote partnership—but this is another topic.

Clinical supervision may carry with it the association to mental health too strongly for it to be used as the word or phrase for this interactive, educative relationship within other fields. And supervision alone, without the word clinical modifying it, may suggest a too mechanistic approach. Perhaps the word mentorship is more appealing and carries less baggage. In any case, whatever it is called and whatever the exact purposes of the process are, it needs to be a place where a supervisee is treated in such a way that she feels free to raise issues of all kinds that interest or concern her. What

As the field of early intervention moves to a family focus, understanding the impacts of relationships is essential.

One must always take time to think before acting.

should be talked about is what needs to be talked about. It differs from any kind of therapy, although in any setting it may be therapeutic, because it does not focus on nor intend to investigate the privacy of the supervisee's inner life except as it naturally arises in the understanding of the performance of his work. Even then, it is discussed in a comfortably circumscribed way —not pursued for its own sake.

It is easy to imagine a seasoned practitioner in any of the fields of early intervention being of enormous help to a new practitioner in advancing understanding of the skills and subtleties of her work both technically and interpersonally. The supervisory relationship provides the place for exploration, creativity and understanding which will not only advance but possibly transform the practitioner's work in basic, permanent ways. It is a perspective that is created. If such efforts cannot be weekly or one-to-one, the effects will be different but not diminished and perhaps in particular ways, even enhanced. If meaningful relationships for the purposes of understanding and exploring are formed that are safe, mutual and respectful, then supervision, or mentoring is occurring in a positive way.

I can imagine, and I absolutely love the idea, of flying a plane into a rural area (preferably in the midst of an incredible snow storm) in order to meet once every other month with a lone practitioner who is providing early interventions that meet a variety of needs of families in the area. More sensibly, I can imagine an assessment of what the supervisory needs are in particular geographical areas and sending in appropriate teams to work with the practitioners to better help them meet those needs. Assistance with technical skills would be provided as well as a general understanding of one's role and relationship with those with whom one works. My point is, that we must be neither too precious nor rigid about the form clinical supervision or mentorship take as long as we demand that it exists in some form. If we are clear about both its parameters and purposes we can be as creative as we need to be.

It occurred to me as I was writing this that I have, only in the last 14 years, individually supervised for one hour a week for over a year or more about 125 people within the Infant-Parent Program. I remember every single one of them. Probably each of us has come to know unique parts of the other as we have needed to in working together in regard to particular families. The intensity of what we do together in supervision,—the hard work, the sadness, the responsibility, the worry, the pleasure, the joy and the delight are really very special. In addition, we share something with one another that we share with absolutely nobody else and that is our intense investment in particular, specific other human beings. It is like being some kind of devoted mini-family—a duo, determined that together we will somehow understand and make something better for this family that we've come to care about. In order to do this, we have to consider everything relevant that we can possibly think of and to be as creative as possible in thinking about what we might do.

I do not have anything like the same relationship with each person I have supervised, but all of the supervisory relationships have been marked, I think, by mutual respect, affection and generosity of spirit on both sides. I carry within myself specific and unique things that I have gotten from each of them that I bring to each new trainee even as I add their contribution to my understanding of the world. I know that many of the families to whom we have devoted our understanding, gained from our mutual efforts tremendously and I know that others failed to, but it was not from want of trying or caring. I know also that each subsequent family will benefit from what we learned together.

I have a rule at the Infant-Parent Program that I make clear for all new trainees. Simply put, it has to do with never making a difficult decision alone. There will always be someone available to think with someone who needs to make a grave decision. I do this, I think, for several reasons. It creates the notion that one must always take time to think before acting and that two people thinking are probably going to do a better job than one alone. It also ensures that no-one is ever abandoned to make what are

sometimes life-shaping decisions for which no single person ought to bear the responsibility. What occurred to me about this as I wrote, was that something akin to this exists in supervision and has a very important effect. I think a practitioner, particularly in the beginning, can only allow herself to know how terribly important things really are if the burden for it all doesn't rest entirely on herself. I think that sense of being able to depend on someone else is, in and of itself, extremely important in allowing practitioners to come to grips with what they feel and to acknowledge and register what they observe. This, of course, will be a crucial factor in how they proceed. The data will actually be different. As I thought about it I realized that there were some very troubled families whom a supervisee and I have struggled hard to keep together, whom I would not have found the courage to maintain alone—nor would the supervisee. This is a dramatic example but it illustrates what I think is true of supervision in general. It is the place where you can slow down, think with someone and try to understand as much about the things that are happening and how you are feeling about them before you decide what to do. This allows for different decisions to be made. This is not to say that much of what we do is not also spontaneous, in the moment, and retrospectively untraceable but even this probably rests on a sense of trust in our own internal responses—a trust developed over time, certainly through experience, but particularly developed out of the opportunity to depend on the support of a supervisory relationship. Supervision is the vehicle for the transmission of the competence and professionalism of a supervisor to a supervisee in the context of that supervisee's unique skills and personhood. It is important for us to be imaginative in recognizing the many shapes such learning relationships might have and in determining how they might be put in place for the benefit of all of the work which practitioners do with infants, toddlers and their families. No work could possibly be more important and it deserves our very best.

Two people thinking are probably going to do a better job than one alone.

5

Teaching Family-Centered Skills through the Case Method of Instruction

P.J. McWilliam

The movement toward a family-centered approach to services for infants and toddlers has been cause for much celebration over the past decade. In fact, ever-increasing levels of parental control and authority are being advocated by leaders in the field, and not only in matters concerning parents and their own children, but also in decisions affecting the direction and day-to-day operation of entire programs. New terms appearing in the literature reflect this trend, moving from family-focused, to family-centered, and most recently to family-directed service provision.

Despite nearly universal agreement on the need to adopt a family-centered approach, implementation in early intervention programs has proven to be quite difficult. The challenges facing programs and individual practitioners are many and complex. For example, in many programs and communities there are organizational barriers to implementing a family-centered approach. Among these are caseload requirements, reimbursement policies, the type and amount of paperwork required, the scheduling of services, limited availability of appropriate resources or services, a lack of shared values among team members, and poor interagency communication and coordination (McWilliam, 1993). Such barriers vary considerably from one community to the next, and overcoming them requires considerable creativity, effort, and ingenuity on the part of service providers.

Difficulties also arise from the fact that there are no clear step-by-step procedures for implementing family-centered practices. Family-centered care is a philosophy about the manner in which services are be provided. This philosophy is based on a set of deeply held values and assumptions about the important role of parents in making decisions that affect their children and their family as a whole. The philosophy also acknowledges the reciprocal nature of family well-being and child development and, therefore, advocates that services be expanded to include support to the family as a whole rather than being restricted to child-level services. Implementing this philosophy requires a thorough understanding of each family's priorities and the ability to work together in true partnership with parents to develop and implement an intervention plan that facilitates the accomplishment of each family's unique priorities. The characteristics and circumstances of families participating in early intervention services vary widely, as do their priorities for intervention. The challenge facing practitioners is to individually tailor their work with each child and family in accordance with the basic principles of a family-centered approach.

Finally, there is a growing realization that the personal values and beliefs of practitioners can significantly interfere with their ability to engage in family-centered practices (Christensen, 1992; Johns & Harvey, 1993; Lynch & Hanson, 1993; McWilliam, 1993). The principles of a family-centered approach dictate that family values and priorities, rather than professional opinions, should guide the identification of child and family goals and all decisions regarding service delivery. Difficulties in adhering to these principles arise when there is a conflict between what the family values and what the

P.J. McWilliam, Ph.D., The University of North Carolina, Chapel Hill, North Carolina

professional values. Given the rapidly increasing number of families from diverse cultural backgrounds who are participating in early intervention programs (Christensen, 1992; Lynch & Hanson, 1993), conflicts are likely to increase. This issue brings forth a very different type of challenge for practitioners, and that is to be aware of their personal values and beliefs and how they influence their work with families. For without such self-awareness, differences in values are likely to be misinterpreted as differences between right and wrong and preclude acceptance of cultural and individual diversity.

The extent to which the promise of family-centered services is eventually realized will, in large part, depend upon the efforts and abilities of those responsible for personnel preparation. This includes both inservice trainers attempting to re-tool our current workforce and preservice instructors preparing early interventionists of the future. But how does one go about teaching a philosophy, when enactment of that philosophy requires overcoming a multitude of organizational barriers, self-awareness of one's personal values, and the forming of caring and trusting relationships with people of diverse cultural backgrounds? Traditional methods of instruction seem ill-suited to the task. A method that I have found to be far more promising in the teaching of family-centered practices is the case method of instruction (CMI) (McWilliam, 1992). Over the past 6 years I have used CMI with both preservice and inservice audiences and it has been well-received by both groups. Furthermore, preliminary efforts to evaluate its effectiveness (Snyder & McWilliam, 1994) have shown that CMI has the ability to effect significant changes in participants' knowledge, attitudes, and application skills. While I make no claims that CMI is the only alternative training strategy available, it does appear to have desirable effects and may provide at least one alternative to traditional training strategies.

The case method of instruction

CMI focuses on the teaching of application and decision-making skills within the context of real-life situations. Students or trainees are presented with a detailed description of a situation encountered by a professional or group of professionals. The situations are similar to those that early interventionists are likely to face in their routine work with children, families, and other professionals. Each case story features a central issue such as how to present "bad news" to parents, how to handle situations in which other professionals are judgmental of a family, how to handle instances of suspected abuse or neglect, or how to work with parents who are angry or uncommunicative. In each case story, the situation is left hanging. It is clear that the professional or group of professionals featured in the story must decide on a course of action to improve the situation they face. Most important, there is no one obvious solution to the dilemma, but rather a number of reasonable alternatives. The instructor serves as a facilitator and leads participants through the process of arriving at a solution to the situation presented in the case story. This decision-making process involves analyzing the factors contributing to the situation, identifying possible alternatives, weighing the pros and cons of each alternative, deciding on the most favorable alternative, and developing a course of action to follow in order to implement their choice. The facilitator leads the group by posing open-ended (and occasionally provocative) questions. To the extent possible, participants should be left to carry the discussion, but a good facilitator is crucial to obtaining the desired results of the method. One of the most important qualities of facilitators is their capacity to remain nonjudgmental about participants' comments or suggestions. Doing so becomes easier with experience in using CMI, and instructors also come to realize that the process leading up to the solution of a case story has more instructional value than the solution itself.

CMI focuses on the teaching of application and decision-making skills within the context of real - life situations.

Decision-making

I have used CMI with preservice and inservice audiences to teach family-centered practices. A common error made by students and trainees is to jump immediately into offering solutions to the case under discussion. At times it requires much effort on my part to gently loosen their hold on the solution(s) they have offered and encourage participants

The role of the facilitator is to question assumptions without criticizing participants.

to engage in the process of analyzing the situation and identifying alternatives prior to making a final decision. This tendency of participants to offer premature solutions and thus circumvent critical steps in the decision-making process may reflect one way that the application of family-centered principles can go awry. That is, if parents raise a concern and practitioners respond by immediately offering advice and recommendations, the process of actively engaging parents in the decision-making process is precluded. Instead parents are left with only one decision—to accept or reject the practitioner's recommendation. Through case discussions, participants can be made aware of any tendencies they may have to offer advice too soon and the effects that doing so can have on parents. Furthermore, this tendency seems to lessen with each case story discussed, as participants gain more experience with the decision-making process and applying family-centered principles.

Verifying assumptions

Another common error made by participants in case discussions is to make unwarranted or only partially verifiable assumptions about characters in the case stories. In particular, participants make assumptions about the motives of parents based upon very little evidence. For example, I use a rather short case vignette entitled "Supermom" about a family that includes a 10-month-old with Down syndrome. The mother wants increasingly greater amounts of therapy for her son and is also pursuing cosmetic surgery, weight control, and other interventions she has read about. I am always surprised at the assumptions participants make about this mother and at how strongly they are convinced of the truth of their assumptions. Participants often say that this mother is obviously in denial, has not accepted her son's disability, hasn't finished her grief work, and has failed to bond with her son. The judgments about this mother can, in fact, be quite harsh. I am equally surprised at the assumptions participants make about the child's father. The story briefly mentions that the father was shaken by the child's diagnosis of Down syndrome at birth but that he appears to have recovered. The father is a promising lawyer who has hopes of soon becoming a partner in the law firm where he works. He works long hours and is seldom present when the interventionist conducts home visits. All contacts with professionals and decisions related to intervention for the child are the mother's responsibility. Some participants have said with grave certainty that the father is in denial and is using his work to avoid facing the truth about his son. Other participants have said with equal certainty that the mother is pushing the father away or protecting him. Ascribing motives to people based on a paucity of information is not uncommon. We all do it, and we do it often. **Acting** on the basis of unverified assumptions, however, can be detrimental to the development of effective partnerships between parents and professionals. When assumptions such as those described above are made during case discussions, the role of the facilitator is to question the assumptions without criticizing participants. I may ask, for example, "How do you know that?" or "Is there any other reason why [parent's name] might have said [or done] that?". The objective is not, of course, to uncover the "true" motives of the parent portrayed in the case story, but rather to help participants become aware that they are making unverified assumptions. At times it may be appropriate to go a step further with the group and explore strategies they could use to check out their assumptions.

Self-awareness

CMI can be powerful in addressing a number of other factors that influence the quality of relationships between parents and professionals and, consequently, the ability of professionals to engage in family-centered practices. One of these factors is self-awareness of personal values and beliefs. It is not unusual for participants to express strong opinions during case discussions about what needs to be done. For example, in a discussion of the "Supermom" vignette, at least one participant in the group usually feels very strongly that the mother is harming her child with her incessant quest for more therapy, and that she needs to be "stopped" and made to understand how important it is to just play with him and let him "be a child." Participants often express similarly strong emotions and opinions about the mother's interest in

cosmetic surgery. Some participants appear to have difficulty recognizing that their opinions are a product of their own values--values that were instilled in them either through professional training or through their own cultural or family experiences. Rather than acknowledging a difference between their own values and those of the mother in the story, participants view the situation as a conflict between right and wrong. Again, nonjudgmental questioning by the facilitator can expose issues of diversity in cultural and personal values and help participants understand how their own values can have a profound influence on their work with children and families. The different opinions expressed by other members of the group can further heighten participants' awareness and sensitivity to the issue of personal values.

Communication skills

CMI can also be used to work on communication skills. Shortly after I began to use CMI, I realized how difficult it was for students and even many veteran practitioners to find the right words to say to parents. Although I was surprised by this at first, I shouldn't have been, considering that professional training programs rarely include training in communication skills, except for perhaps a brief overview of a few standard interviewing techniques such as reflective listening. Effective relationships between parents and professionals form the basic foundation of family-centered service provision. Respect, trust, caring, and understanding are all components of parent-professional relationships, and their development is highly dependent upon communication.

When using CMI, I sometimes interrupt the discussion and conduct impromptu role plays in order to work on communication skills. Participants' comments such as, "I would explain to the parent that...," or "I would talk to the parents and try to find out..." provide an opening for moving into a brief role play. To do this I might say something such as, "Let's suppose the professional in this situation decided to do just that. What exactly might you say to the parent if you were the professional in this situation?" I usually offer to play the part of the parent and participants try their hand at a conversation with me. Rather than engage in an extended role play, I stop the conversation frequently and have participants discuss how it is going. When the role play is resumed, another participant may take up where the previous participant left off, either continuing the conversation or starting over using a different tactic. Team simulations are another way to work on communication skills.

Situations related to a case story such as an IFSP meeting, transition-planning meeting, or a parent conference following a child's assessment set the stage for participants to engage in team role plays and to practice communicating with parents. The facilitator can play the role of the parent or give participants a written description of the parent's perspective so that they can take on the parent's role in the simulation. Participants often report that playing the role of the parent is a real eye-opener for them. Whether using impromptu role plays or team simulations, I find that the instructional value is not in the role play itself, but in the discussions that surround it. It is through feedback and discussion that participants become aware of how the words they choose and their ability to listen affect the development of relationships with parents.

Clearly, CMI cannot solve all of the problems we face in implementing family-centered service provision. The issues that must be addressed extend well beyond those that can be handled through personnel preparation alone. The focus of CMI on teaching application skills, however, makes it an attractive alternative to more traditional training methods. The decision-making process taught through CMI may help prepare trainees to handle effectively the inconsistencies and uncertainties that are reality in early intervention and in most other human service fields. Through CMI participants learn how to think for themselves, carefully analyze each situation they encounter, and then to draw upon their accumulated knowledge and experience to arrive at a well-thought-out decision and course of action. Finally, CMI provides a means of teaching skills that enable practitioners to develop relationships with parents in accordance with the philosophy of family-centered service provision.

Non-judgmental questioning can help participants understand how their own values influence their work.

References

Christensen, C.M. (1992). Multicultural competencies in early intervention: Training professionals for a pluralistic society. *Infants and Young Children*, 4(3), 49-63.

Johns, N. & Harvey, C. (1993). Training for work with parents: Strategies for engaging practitioners who are uninterested or resistant. *Infants and Young Children*, 5(4), 52-57.

Lynch, E.W. & Hanson, M.J. (1993). Changing demographics: Implications for training in early intervention. *Infants and Young Children*, 6(1), 50-55.

McWIlliam, P.J. (1992). The case method of instruction: Teaching application and problem-solving skills to early interventionists. *Journal of Early Intervention*, 16(4), 360-373.

McWIlliam, P.J. (1993). Real-world challenges to achieving quality. In: P.J. McWilliam & D.B. Bailey (Eds.) *Working Together with Children and Families: Case Studies in Early Intervention*. Baltimore: Paul H. Brookes.

Snyder, P. & McWIlliam, P.J. (1994, October). Evaluating outcomes from the case method of instruction: Data-based support for use of the approach in early intervention personnel preparation. Research poster presented at the International Early Childhood Conference on Children with Special Needs (DEC), St. Louis, Missouri.

Case stories about early intervention are available through The CMI Project. Please write to: P.J. McWilliam, Ph.D., Frank Porter Graham Child Development Center, CB# 8180, The University of North Carolina, Chapel Hill, NC 27599-8180.

6

Parallel Processes

Karen C. Mikus, Rita Benn, and Deborah Weatherston

A training vignette

Gradually, fifteen people gather in the comfortable meeting room. The training facilitator greets each person by name and moves quietly among the group, talking briefly and listening carefully. During the opening minutes of the training session, the facilitator invites group members to share their experiences since the last session two weeks ago. One of the group members, an early intervention teacher, describes her feelings of being overwhelmed and frightened by the amount and intensity of anger which has been directed at her by a family with whom she works.

The facilitator pushes her notes to one side, temporarily suspending the training agenda for the afternoon. She leans forward and listens intently as the teacher responds to her request, "Tell us more about this." The ensuing discussion focuses on the feelings stirred up in professionals as they work with families. Soon, another group member refers to an earlier presentation having to do with cultural differences regarding help-seeking. A deeper understanding of the family's perspective then emerges; gradually, the teacher feels less attacked and distressed and is able to more clearly imagine what she might do next to mend her relationship with this family. When it is clear that the teacher has received both concrete ideas and emotional support, the training facilitator returns to her notes and asks the group to prioritize with her the items they had previously planned for today's training agenda. The training then proceeds. Some time later, in response to a family's story of loss and grief, one of the group members begins to cry softly as she talks about the sorrow she so often feels when one of 'her' early intervention families encounters yet another loss. One of the group's parent consultants shares her perspective as the parent of a child with special needs. The exchange which follows results in a blended picture of the impact of loss on the family members and on the professionals with whom they work. Towards the end of this discussion, someone comments in frustration about another family's "denial" and seeming failure to accept their child's condition. This triggers an additional round of exchange. The leader asks the group to think about this family's strengths and the possible positive function of the family's refusal to acknowledge out loud to professionals the full extent of the child's disability. Again, the facilitator continues with the day's topics only when the participants feel fully 'heard' and supported.

The session ends with some reflections on the strengths and capacities which were evident within the training group this day. The facilitator inquires about specific concerns to address in the training session that is scheduled in two weeks' time.

The facilitator stays beyond the end of the session and chats with participants as they leave. One of the group members lingers until all of the others have gone and then asks the facilitator how he might deal with conflicting philosophies of practice in his agency. He wishes to become more family-centered in the services he delivers but is encountering obstacles within his own organization and within the community. They talk and problem-solve together for some time and the facilitator agrees to send him an article related to this issue.

The facilitator leaves feeling satisfied and tired as well as somewhat emotionally drained. Attending to individual needs and

Karen C. Mikus, Ph.D., Center for Human Development, William Beaumont Hospital, Royal Oak, Michigan

Rita Benn, Ph.D., Merrill-Palmer Institute, Wayne State University, Detroit, Michigan

Deborah Weatherston, M.A., Merrill-Palmer Institute, Wayne State University, Detroit, Michigan

Our training is designed to build awareness that thoughts and feelings have a central impact in the provision and success of early intervention.

responses is difficult work. She looks forward to the opportunity to share her training experiences and the accompanying feelings the next day with the team of training facilitators.

Later in the week, she calls the group member who had been tearful and the parent who had shared so many of her feelings in order to provide support to her fellow group member. She also phones her state level Part H contact person to up-date her regarding the training session and to engage in some problem-solving related to the development of a new community in the state as a training site. She sends the article she had promised with a note of interest and support.

This is an account of one of the early intervention training sessions sponsored through Project F.I.T. (Family-centered Infant and Toddler Transagency Training) at Merrill-Palmer Institute at Wayne State University in Detroit, Michigan. Project F.I.T. was funded through both federal and state grants to deliver interagency, infant/family-centered training for early intervention personnel as the State of Michigan prepared to implement Part H legislation. The need for personnel to have a time and place where they could meet regularly, begin to understand each other's work, reflect on their experiences working with families, and explore together a different way of service delivery provided the impetus for the structure and content of this training model. An emphasis on relationships and on building awareness that thoughts and feelings have a central impact in the provision and success of early intervention served as the organizing framework for the design and delivery of this training. The importance of placing the infant and her/his family at the center of every intervention was a central focus in the development of the training materials and throughout every training experience.

Overview of the training program

Over 275 professionals and parents of children with special needs in 13 Michigan communities participated in an intensive, small group training over a two year period. Every training group met regularly for a total of 32 hours over a period of several months. Each group included at least one training facilitator and two parents from the community who had children with special needs. The parents were active participants and served as ongoing consultants to the group and the training facilitator as infant/family-centered practice and parent-professional partnerships were explored. Between 12 to 23 practitioners from local community agencies representing Public Health, Mental Health, Social Services, Education and service programs from the private sector participated in each interagency training group.

The training occurred in two distinct, consecutive phases: (1) a topic-focused phase and (2) a consultation phase. Topics addressed in the first phase included infant and family relationships, diversity, the impact of a child with special needs on the family, grief and loss, parent-professional partnerships, professional-professional collaboration, and personal and professional response in early intervention work. These content areas were chosen to stimulate in-depth discussion of key issues related to family-centered practice. Exploration of these topics was seen as fundamental to enabling professionals from different backgrounds and levels of experience to focus or refocus their practice from child- to family-centered, from expert- to partnership-based, and from service-driven to relationship-focused. In every session, key concepts of a topic were introduced using brief lectures, hands-on activities, videos and/or parent presentations. Participants were always invited to share their perspectives, voice their concerns, and explore the impact of infant/family-centered principles on their own practice. These repeated opportunities for discussion were critical in helping participants integrate their thoughts and feelings about an infant/family-centered approach to intervention. The topic presentations in conjunction with rich group discussions enabled participants to enhance their levels of understanding and skill. For many group members, this was the only scheduled opportunity they had to reflect on the services they were providing and their emotional responses to family-centered work.

The second phase of the training involved the application of family-centered principles to the infant and family practice of each of the trainees. As participants shared the stories of the babies and families with whom they worked, the facilitator provided consultation, guidance and support. Issues related to the development of Individualized Family Service Plans were discussed as professionals who worked together with the same families shared their views and modified their existing approaches to intervention. Issues related to interagency collaboration and parent-professional partnerships were again addressed in the context of direct and immediate implementation of family-centered early intervention programming.

While the training was organized in two consecutive phases, in reality, this division was not always apparent. In some cases, participants shared stories of the families with whom they worked during discussion of material presented in Phase I: Topics. Consequently, the focus of such a session would shift to providing consultation to the participant around the particular issue raised. Later, during the consultation phase, it was often useful to revisit many of the topics and concepts presented in the first phase. As participants had the opportunity to reflect on their approaches to early intervention, and to practice family-centered strategies in their ongoing professional roles, they sometimes wanted more in-depth, topic-specific information.

Outcome of the training

A number of outcomes of the training for the trainees, the parents, the training facilitators and project leaders have been identified. For most trainees, the model was effective in shifting participants' knowledge of and responsiveness to families. Pre- and post-analysis of a quantitative index of early intervention attitudes of professionals indicated a significant shift towards collaborative family-centered practice (Benn, Weatherston, Mikus, and Mann, 1993). The training also served as the basis for developing community-based, transagency collaborative networks. After the training was completed, some trainees began to serve as the nucleus for organizing service coordination and advocacy in their communities. Some training groups continued to meet regularly to discuss issues related to implementing family-centered early intervention practice. Such meetings served to reduce the isolation they had felt previously in their early intervention work. Several of these groups later opened their membership to other professionals who wished to learn more but had been unable to participate in the full training program. Some of these groups have continued well beyond the life of the training grant.

The training served as the basis for developing community-based, transagency collaborative networks.

Similarly, parent participants became active in community leadership roles and on statewide policy committees. One parent became the first parent ever to sit on a human service coordinating council consisting of the directors of all the major local agencies interested in prevention programs. The same parent organized the development of a cross-system parent-professional coalition in her community. Another parent was hired as a consultant to assist in Part H implementation in her region. In each training, parent-professional collaborations were enhanced. Parents were sometimes surprised to see the depth of feeling and caring professionals experienced in relation to the families they were serving. In many cases, new relationships between parents and professionals were forged within the context of the training.

Other changes also took place, including increased depth and breadth of understanding on the part of the project training leaders. For instance, one leader expanded her perspective from an infant-parent focus to a more inclusive stance which more fully recognized the importance of all family members to the development and well-being of an infant. Another became more keenly attuned to providers' personal responses to family-centered work. Still another became more mindful of the process and effects of change which professionals encountered by participating in family-centered training.

For all project leaders, the value of parents in training was heightened. Not only could parents consult to a training group, but their voices were critical in teaching

The joys and pain, satisfaction and agony which families experience came alive when parents shared their families' stories.

and driving home the family-centered concepts which trainers presented. When parents spoke in person, professionals were able to listen and understand in ways which were very different than if the same messages were relayed by another professional. The joys and pain, satisfaction and agony which families experience came alive in meaningful and lasting ways when parents shared their families' stories. Project training leaders discovered many ways to present material without using clinical jargon or emphasizing pathology. In addition, training group leaders and facilitators learned more about the conditions and intensity of the struggles that participants faced in their work in human services. For some professionals, participation as trainers led to further professional growth and leadership roles in their communities. For example, one training facilitator became more confident in her ability to draw upon her own clinical experiences and understanding. She then led several other training groups and went on to become a key person in providing training leadership in early intervention in the state. She had found her training "voice."

Application of family-centered principles of practice at multiple levels throughout a training

In the course of developing and implementing this early intervention training project, it was repeatedly evident that certain principles of infant/family-centered practice were essential not only to effective work with families but also to the successful implementation of an early intervention training process. That is, many of the guidelines for best practice for family-centered service delivery had to be applied directly to the trainers' interactions and relationships with professionals at all levels of the ecosystem in which the training was embedded. Without sensitive and skillful application of infant/family-centered principles and practices at these multiple levels in various contexts by the trainers, the interagency training itself would have been jeopardized and its effectiveness compromised. In addition, it became apparent that active implementation of these principles throughout a training was essential regardless of the composition of a particular training group. That is, experienced as well as novice professionals were able to benefit from this training approach as did a range of disciplines and staff members from a wide variety of agencies and programs. Finally, these tenets are ones which can be usefully applied to every training situation - whether inservice or preservice, long-term or single workshop.

1. Relationships are of central importance and form the basis for ongoing work and service delivery.

In order to promote practice with a relationship-focused perspective, it was essential for the training group leader to model the principles of family-centered, collaborative practice which the participants were being asked to implement in their relationships with families. Thus, trainers had to nurture the development of relationships within the group and between the group and the trainer. The high priority placed by Project F.I.T. on sustaining relationships guided trainers when they confronted choices about direction, content, and process with particular groups. Project leaders and trainers learned to build in many degrees of freedom so that each training could be relationship-focused and changes necessary to promote relationships could be made as needed. In addition, careful attention was paid to the trainer's relationships with the communities and systems in which the trainees worked, to the state in which the training and early intervention work took place, and to the funding agent's systems. As demonstrated in the training vignette, time had to be allotted to talk with Part H staff at the local and state levels to gather information and input which was then used to modify the training content and process.

2. The provision of support is critical to effective early intervention programming.

This principle became a prominent focus in all trainings. The format and content of the training were specifically designed to create "safe," accepting contexts in which practitioners could receive (and provide) support for family-centered practice. The parent consultants in Project F.I.T. groups

also received support from the training group leader and fellow group members. In addition, support from other parents participating in the same training experience proved to be valuable; for this reason, whenever possible, there were at least two parent consultants recruited for each training group. In order to provide the support which the trainers needed, the training facilitators met regularly to exchange ideas and experiences and to problem-solve when faced with questions or difficulties. Sometimes, the main focus of these team meetings was the recognition of the emotional drain which often occurs when one is intensely involved in family-centered, relationship-based training and practice. Certainly, the state leaders in Part H needed support for the work they were doing on behalf of families with young children. When appropriate and possible, the training facilitators offered a listening ear, ideas, and support as they interacted with state level Part H staff.

3. Collaborative partnerships are essential for effective outcomes.

Just as family-centered practice requires professionals to relinquish the role of expert decision-maker for the family, family-centered training requires trainers to enter into a collaborative relationship with each training group and with individual trainees. This meant that Project F.I.T. trainers worked closely with groups to develop and/or revise training agendas and the specific emphases of each session. As the training vignette shows, trainers were given "permission" to suspend or adjust the training agenda in order to address the immediate needs of each group. This is not dissimilar to the family-centered service provider who must suspend the intervention agenda when working with families in order to address pressing family concerns which were not initially identified.

At the community level, collaboration with key players and gatekeepers was essential in assessing the community's readiness for a training program and in developing the training implementation plan and time table.

4. Listening, observing, and responding respectfully are key strategies.

Listening, observing, and responding in respectful and caring ways foster the development of collaborative partnerships, whether the players involved are service providers and parents, all service providers, or a trainer and trainees. The efficacy of such an approach, implemented genuinely and honestly, cannot be overestimated. Using these strategies in interactions with the training group and its members enabled Project F.I.T. leaders to model the approach recommended for service providers in early intervention work. In addition, through the use of these strategies, the trainers gathered more information about each group and community and deepened his/her understanding of salient needs and concerns. It seemed that, as group members and state leaders themselves experienced what it is like to be "heard' and valued, they were better able to respond caringly to families and colleagues.

5. Emotions must be acknowledged and supported rather than ignored or minimized.

As practitioners develop relationships with families, they are exposed to the pain and sorrow, frustration and struggles which families so often experience. In addition, the work of early intervention itself evokes many feelings within service providers and can be emotionally intense and exhausting. At the training level, the experience of delivering a state-wide family-centered training stirred many emotions in the trainers and project leaders, including frustration, satisfaction, disbelief, pleasure, impatience, feelings of efficacy, feelings of inadequacy, and many more. At the state level, it seemed important to recognize how emotionally difficult it may be for Part H policy leaders to develop family-centered policy and to act as family and child advocates within the realities of politics and funding. From every perspective, then, infant/family-centered work is emotionally evocative.

As it is important for service providers to sit quietly with a parent and support her as she cries, so it is important for service providers to have safe and supportive contexts in which to share their tears. The feelings of trainers and policy makers also need to be expressed and acknowledged. Train-

ings and relationships which fostered supportive, caring climates in which feelings were valued provided critical opportunities for practitioners/trainers/policy leaders to express their personal response. Professionals could then explore the ways in which their personal responses and emotional reactions facilitated or hindered their work with families.

6. Respect for cultural values and norms must characterize every interaction or intervention.

Just as service providers must be mindful of the cultural values of the families with whom they work, so must training leaders attend to cultural issues as training is provided. In Project F.I.T., presentations about various cultural perspectives were combined with discussion of value conflicts encountered in professional practice. When a family situation or story was presented, the training facilitator often brought the group's attention to the possible role of ethnic and cultural heritage. Group members' understanding of different cultures was a valuable resource which was tapped to enhance everyone's awareness. Because communities, organizations and groups develop their own "cultures" and norms, every trainer had to move carefully in order to gauge and respect each group's important (though initially, invisible) values or beliefs. For instance, in order to effectively address the issue of providers' personal/emotional responses to family-centered work, trainers had to develop an understanding of each group's norms for being vulnerable in this way. Only then could trainers make creative and sensitive adaptations according to a group's needs and tolerance while emphasizing the importance of recognizing and examining one's personal responses to work with young children. Trainers also had to be prepared to mend relationships when they had, inadvertently, broken a group norm or cultural tenet.

Summary

Experiences garnered during several years of providing Project F.I.T. (Family-centered Infant and Toddler Transagency Training) support the importance and efficacy of adhering to principles of infant/family-centered practice in the development and implementation of early intervention personnel development programs. When the training facilitator follows and models infant/family-centered practices throughout a training experience, participants are able to experience first-hand the positive regard and sense of meaningfulness which results from being treated respectfully and valued as collaborative partners. In this way, participants are empowered to use this approach with the families with whom they work. When community and state leaders are respectfully engaged in a collaborative partnership and problem-solving process with a training project, they feel more informed about the training and approaches of the training staff. They also have the opportunity to experience the positive feelings of being respected and valued for their input which may, in turn, affect their subsequent exchanges with early interventionists and programs in the field. Attention to relationships and key principles of family-centered practice at these multiple levels of the early intervention system—the family, training group, community, and state—protects the training program and supports the widespread implementation of infant/family-centered practices.

7

Reflecting on the Art of Teaching

G. Gordon Williamson

Practitioners in the infant/family field are often asked to teach or present on some aspect of our work. Some of us eventually view teaching or training as our primary role. I have come to recognize just how critical it is to pay very close attention to **how** we teach infant/family professionals and paraprofessionals—not only because our field embraces such a large knowledge base but, perhaps more importantly, because our work includes such a powerful emotional component.

I try to think of my training as modeling the connection between our intellectual and emotional sides. Whether I am preparing a presentation for graduate students or doing inservice training for Head Start, there are certain key principles that I use, not only to make my training as effective as possible but also to provide a structure which allows me to fully enjoy what I'm doing.

In this article, I would like to share training approaches and strategies that I have found particularly useful over the years. I will refer briefly to some pertinent adult learning literature and then highlight specific ideas that can focus and sharpen our training.

Thoughts on adult learning

In the past few years, I have become very interested in research about adult learning. Kolb (1976) identified four basic modes of learning—concrete experience (feeling); abstract conceptualization (thinking, analyzing); active experimentation (doing, practicing); and reflective observation (watching, reflecting). Although no one learns through only one mode, each individual tends to have a preferred style of learning that emphasizes one or two particular modes. In training, it is important to provide a variety of instructional experiences that address the preferred modes represented in any audience. Likewise, trainers need to be aware of their preferred learning style, since there is a tendency to teach primarily in that personally comfortable mode.

Research also tells us that we gain 7 percent of what we learn through hearing, 87 percent through seeing. That statistic should dispel our notion that listening is the primary domain for learning, and that lecturing is the primary domain for teaching. We remember 20 percent of what we hear, 30 percent of what we see, and 50 percent of what we hear **and** see when tested for immediate recall. How much more might we all retain if we regularly discussed and reflected on what we see and hear and had an opportunity to practice and process what we have heard and seen in an active way?

These data suggest that to be effective teachers, we have to develop teaching styles that appeal to adults with different learning styles. This principle is no less important for teaching adults than for teaching children. It applies to 20-minute panel presentations as well as all-day seminars. The more we concentrate and reflect on adult learning, the higher the probability we will be successful in our teaching efforts.

Guidelines for preparing effective presentations

• **Teach to your strengths.** It is natural that we prefer certain teaching formats rather than others. We may find that we're quite comfortable in the give-and-take of a small group but rather ill-at-ease before a large audience. Our most natural and authentic teaching style may emerge in the process of teaching with colleagues rather than

G. Gordon Williamson, Ph.D., OTR
Director, COPING Project, John F. Kennedy Medical Center, Edison, New Jersey
Associate Clinical Professor, Rehabilitation Medicine Department, Columbia University, New York City

presenting alone. We may feel entirely competent in using a variety of audiovisual materials in presentations or prefer to use only slides as a reliable visual aid. It was a relief to me, as an occupational therapist and special educator who has been involved in a great deal of teaching over the years, to be assured by someone whose opinion I respected, that I don't **have** to be equally skilled in all modes of teaching. For example, participating on a panel is for me like pushing a rope—a real struggle. On the other hand, I quite enjoy, as do many others, presenting to large audiences and experimenting with a wide variety of audiovisual materials to enrich and reinforce my words. Regardless of our particular strengths, we need to build a repertoire of teaching skills to enhance them.

• **Clarify teaching goals.** My first step in preparing for a session is to ask: What do I hope to accomplish? What do I want participants to learn, feel, be able to do as a result of their time with me? What do participants think they are going to get? If it's a conference, where am I on the program and how does my session fit into the larger context of the training? Do I primarily want to motivate the audience, impart exciting new information, teach specific skills? What two or three things do I hope the audience will gain? All these questions need to be answered in the planning stage. This takes time!

• **Know the audience.** I try to find out as much as I can about the audience. I want to know which disciplines they represent and something about what their responsibilities are so that I can incorporate their past experiences in my teaching. It is deadly to listen to a speaker who is unattuned to the makeup of the audience and it is unlikely that much learning will occur in this situation. I want to be able to relate **my** knowledge base directly to the trainees' knowledge base and their current and past experiences.

• **Set the right tone.** The opening moments of any presentation set the tone for what is to come. I usually want my tone to be conversational and the content applied and practical rather than strictly theoretical. The issue is to ensure that content is substantive. I value the audience's time and want to use it well. I generally prepare material that is appropriately advanced and challenging so that the audience is stretching forward. In addition to offering some new and stimulating ideas that the audience can take home and immediately put to good use, I try to establish a respectful learning environment in which everyone's background and experience has meaning. I convey the belief that everyone there, including me, can both receive and impart new perspectives and insights and can challenge ideas. This is often accomplished through an experiential, rather than a didactic, approach given the nature of our work. Infant/family practitioners are called upon to constantly interact and build relationships with others—children, families, other professionals. Our teaching can honor and support their work by modeling a reflective and open teaching style. I am convinced that a reflective teaching style leads to reflective learning which then leads to a more reflective practice. Not only is it important **what** I teach but also **how** I teach. How can my teaching help the audience explore what it means to become a competent partner with families in support of the healthy development of infants and toddlers?

• **Develop good handouts.** Participants in training are often consumed with getting every word down on paper. This inhibits them from participating with me in thinking through issues and exchanging perspectives. Written instructional materials free participants from worrying that they won't "get it all" and they free teachers from worrying about not being able to cover all the information. I am less interested in getting through a lot of material than in engaging participants in reflecting on new ideas and approaches. So, I believe in a lot of handouts. I talk about what is in the handouts at the very beginning of the presentation so that participants can direct their attention to the content **and** process of teaching and they will be assured of leaving the session with a study guide. Basically, human memory is weak for the retention

of information. Handouts keep the information accessible over time to aid the integration into practice.

The content of the handouts will depend on the presentation topic but, as a general rule, it is preferable to err on the side of too much information than too little. Some should be targeted at a more advanced level than the presentation itself in order to try to match diverse knowledge and skill levels in the audience. Important diagrams, charts, and tables that are presented through slides and transparencies should also be distributed as handouts. A good bibliography is a must. When the material is reviewed, a humorous handout or two brings back the emotional tone of the session itself and encourages further learning.

• **Develop a "tight" presentation structure.** I often experiment with a number of different ways of organizing a presentation before I settle on the one that seems best suited to a particular audience and situation. Developing a clear organizational structure facilitates my development of training and provides clarity about the session to participants. The introduction is the ideal place to lay out this structure. It prepares the audience for what **will** be discussed as well as for what will **not** be covered. It also helps us decide, among a wealth of ideas and materials we could share, which three or four key points we want people in the audience to remember when they leave.

A typical structure for presentations in our field examines theory, assessment, and treatment. For example, for a presentation on cerebral palsy, motor development is often covered first, followed by assessment procedures, and, lastly, a discussion of medical and therapeutic intervention. Sometimes it is effective to vary that order to provide a new or different perspective on a topic. For example, the presentation on cerebral palsy could begin with assessment—participants observe videotapes and describe the motor functioning of the children. These observations could then lead to a discussion of motor development and the theoretical basis of motor control. From there, treatment could be addressed.

As we sift through our ideas and materials, we will organize them in the most logical and natural way as a start. Then, we can go back, challenge the structure we have and think about whether another way of presenting the topic might be more dramatic or appealing to a particular audience.

• **Design a format to support the structure.** Whatever framework we decide on, we need a lively format to support it. The format may include the use of icebreakers, previews, recaps, and a variety of training techniques meant to enhance learning.

Icebreakers

Beginning and ending a session on time are signs of respect.Icebreakers are of immense value in getting off to a good start in a presentation. I like to begin my training with a provocative statement about infants and toddlers, an interesting or startling statistic about the audience, or a humorous anecdote or video about life in general. Humor is a wonderful way to loosen people up, to make a point, and to establish the beginning of a relationship with the audience. Questions, with a show of hands, help the audience find out who they are and provide useful on-the-spot information for the speaker. Making a promise to the audience about what will have happened by the end of the session underscores the fact that the trainer is serious about this session. Whatever we choose to use, it should suit our teaching style and personality and evoke a reaction that has some connection to the presentation.

Previews and recaps

The icebreaker can immediately be followed by a preview of what the session is about and what kinds of activities the audience can expect. It is a good idea, at least once during the presentation and again at the end, to recap what has been covered to that point and preview what is left to do. At the very end, a brief, pithy review helps participants solidify their sense of how the session fit together and the primary points the speaker is emphasizing.

Frequent changes of pace and activity

A cardinal rule for trainers is that every fifteen minutes or so the training activity

should be changed and the audience given an opportunity to join in. This requires trainers to do some transitioning but prevents us from continuing too long in one teaching mode and underscores my belief in the value of active participation by the audience. I might show a videotape of a baby and caregiver and ask participants to observe and comment on a specific interaction. (In a very large group, the "comments" can be a moment for self-reflection.) I might use any one of a number of small group exercises designed to help participants explore their own responses to particular situations with infants and families. I often use very quick anecdotes from my own practice to illustrate a point and ask the audience for their reactions. Whatever we choose, the point is to encourage participants to actively process and internalize what is being presented.

Anecdotes and case studies

Anecdotes can be very useful in almost any presentation. I deliberately chose ones which clearly illustrate a point and which have high emotional content so that they connect directly with the experiences of the audience. Anecdotes have the added benefit of giving participants a glimpse into the trainer's perspective and work outside the teaching experience itself. I spend considerable time writing down anecdotes that occur during my clinical work that I think might be useful in training. Some of my vignettes are composites of anecdotes told by others and integrated with my own experiences. These vignettes are specifically designed to make a pedagogical statement.

Case studies require much more time and can best be used when there is a sufficient period for discussion. They can facilitate an exploration of complex topics and encourage a deeper level of thinking about perplexing issues faced by infant/family practitioners.

Visual aids

Visual aids—videotapes, slides, and transparencies—can add a rich element to training when the trainer is clear about why a particular medium is being used and makes sure that it is both appropriate and well prepared. We have all participated in training where we could only make out a line or two on a transparency. The print on overheads, for example, has to be sufficiently large and clear to be easily read by **everyone** in the room. How many times have we heard ourselves mumble apologies to those at the back about the size of the print! Videotapes must have clear images and good sound and be cued to the right place. There are no shortcuts to producing high-quality audiovisual materials. However, the results are well worth the effort. They offer a wealth of support to the spoken word and can communicate a great deal in a short period of time I carefully decide which ones would enhance my teaching and exactly when to use them. I often plan a paced sequence of slides, overheads, and videotapes to structure my presentation. Care is taken, however, to avoid switching frequently among media and thus getting "tripped up" by the technical logistics. Slides are my favorite, since they provide such structure, are very helpful for reinforcing information, and lend themselves to almost any kind of presentation. Other trainers could not get through a presentation without using videos to vividly illustrate what they are saying. Whatever choices we make, becoming skilled in developing and using a variety of visual materials takes time and practice.

Audience questions

Allowing or encouraging questions from the audience as they naturally occur during the session can provide useful changes in pace. Some trainers prefer to take questions all at one time, however, and this can often result in a longer, richer discussion than one at a time. Conducting a successful question-and-answer period takes skill. Sample issues include: How to clarify ambiguous questions; how to broaden an individual-specific question to a more generic issue that is relevant to the entire group; and how to manage the individual who is demanding excessive time.

This article provides guidelines for preparing effective presentations. It emphasizes that **how** we teach and **what** we teach are both critically important. Having the sub-

ject matter content is not the same as having the skills to teach it. In a recent survey, speaking in public was rated as the number one fear of Americans—ahead of heights, financial problems, and death. I rather imagine it is because they do not have the **how**.

Selected references

Bachrach, L.L. (1988). On exporting and importing model programs. *Hospital and Community Psychiatry*, 39, 1257-1258.

Bachrach, L.L. (1989). The legacy of model programs. *Hospital and Community Psychiatry*, 40, 234-235.

Briggs, K.C. & Myers, I.B. (1983). *Myers-Briggs Type Indicator*. Palo Alto, CA: Consulting Psychologists Press.

Dunst, C., Trivette, C., & Deal, A (1988). *Enabling and empowering families: Principles and guidelines for practice*. Cambridge, MA: Brookline Books.

Dyer, W.G. (1987). *Team building: Issues and alternatives* (2nd ed.). Reading, MA: Addison-Wesley.

Eggbeer, L., Fenichel, E., Pawl, J., Shanok, R.S., & Williamson, G.G. (1994).Innovative strategies for teaching relationship concepts and skills to infant/family professionals. *Infants and Young Children*.

Foley, G.M., Hochman, J.D., & Miller, S. (1994). Parent-professional relationships: Finding an optimal distance: *Zero To Three*, 14, 19-22.

Hazel, R., Barber, P.A., Roberts, S., Behr, S.K., Helmstetter, E., & Guess, D. *A community approach to an integrated service for children with special needs*. Baltimore: Paul Brookes.

Kagen, S.L., & Neville, P.R. (1994). Parent choice in early care and education: Myth or reality? *Zero To Three*, 14, 11-18.

Kouzes, J.M. & Posner, B.Z. (1993). *Leadership Practices Inventory: Observer*. San Diego, CA: Pfeiffer & Co.

Mattingly, C. & Fleming, M.H. (1994). *Clinical reasoning: Forms of inquiry in a therapeutic practice*. Philadelphia: F.A. Davis.

Mattingly C. & Garro, L. (1994). Narrative representations of illness and healing: Introduction. Special issue. *Social Science and Medicine*, 38, 771-774.

Myers, P.B. & Myers, K.D. (1985). *Manual: A guide to the development and use of the Myers-Briggs Type Indicator*. Palo Alto, CA: Consulting Psychologists Press.

Robertson, S.C. (1992). *Find a mentor or be one*. Rockville, MD: American Occupational Therapy Association.

Rogers, E.M. (1983). *Diffusion of innovation* (3rd ed). New York: The Free Press.

Stern, D.N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Summers, J.A., Dell'Oliver, C., Turnbull, A.P., Benson, H.A., Santalli, E., Campbell, M., & Siegel-Causey, E. (1991) Examining the Individualized Family Service Plan Process: What are family and practitioner preference? *Topics in Early Childhood Special Education*, 10, 78-99.

Zeitlin, S. (1985). *Coping Inventory: A measure of adaptive behavior (Self-rated form)*. Bensenville, IL: Scholastic Testing Service.

Zeitlin, S. & Williamson, G.G. (1994). *Coping in young children: Early intervention practices to enhance adaptive behavior and resilience*. Baltimore: Paul H. Brookes.

8

Using Relationship To Teach Relationship: The risky business of role playing

Rebecca Shahmoon Shanok, with Linda Eggbeer and Emily Fenichel

Editors' note: Since its establishment in 1977, ZERO TO THREE has focused much of its attention and energy on improving the education and support of individuals who work with infants, toddlers, and their families. Beginning with the 1988-90 TASK (Training Approaches to Skills and Knowledge) project, ZERO TO THREE has been championing the importance of regular, collaborative, reflective supervision as a key element in the training and ongoing professional development of all infant/family practitioners—whatever their discipline or work setting. But many front-line practitioners, administrators, and even trainers who are currently in the field have never, themselves, had an experience of supportive supervision. How is it possible to convey to them the essence of reflective supervision—a complex intellectual and emotional relationship that occurs over time, and in private?

In two training-of-trainers initiatives (the 1990-91 Training of Trainers Intensive Seminar and the 1992-93 City TOTS), at the Forum for Educators and Trainers, and at our 1994 National Training Institute, Rebecca Shahmoon Shanok and colleagues from the ZERO TO THREE Board and staff experimented with the use of role play to teach audiences of varying sizes and compositions about reflective supervision. In the interview below (edited excerpts from several telephone calls between Rebecca, Linda, and Emily), Rebecca reflects with us on our experiences over the past five years and our role-playing plans for the future. Sidebars include dialogue from the role play presented at a pre-institute seminar on supervision given by Rebecca and Linda Gilkerson, Ph.D. at the December, 1994 National Training Institute. A videotape of this seminar will be available in Spring, 1995.

Rebecca Shahmoon Shanok, M.S.W., Ph.D., Jewish Board of Family and Children's Services, New York City

Linda Eggbeer, M.Ed. and *Emily Fenichel*, M.S.W., ZERO TO THREE/National Center for Clinical Infant Programs

Q. *What do you mean by "using relationship to teach relationship"?*

A. Relationship is at the heart of the art **and** science of our fields. In our of work with infants, toddlers, and their families, the issue is not just learning content; we need to learn to shift in our perspectives to encompass new roles, new ways of conceiving our roles, and new ways of expanding our capacities within a role. Our field is about **becoming.** How does a person become something? How does a child become a grown-up? How does a young man become a Dad? How does a young worker in our field become an observer of nuance, a reflector about patterns and feeling tones, an introspector, someone open to her own processes, able to take responsibility for her effect on other people?

Relationship is a fundamental and central organizer. Let us recognize it as a very special subset of experiential learning. When we recall the enormous contributions to education of John Dewey, father of experiential learning, or the long history of apprenticeship, across cultures and fields, or, in fact, when we remember how babies learn to become mothers or fathers, we realize that practitioners need to be "brought up" and "held" in our fields.

This kind of learning is truly exploration—there aren't any "right" answers out there, waiting to be memorized. It is more like a demanding journey, and good supervision is like finding a fellow-traveler on such an arduous trip—someone who has been to some of these islands before,

not a master or a tour guide, just someone who has some experience, some survival skills, and ideas about where and how to take the next step.

Q. *Where does role playing fit into this?*

A. Role playing helps us deal with the paradox of trying to teach people about supervision. Here we are, saying that supervision must be an ongoing, collaborative, intimate, protected, reflective relationship that involves regular meetings over a long period of time—and we're delivering this message in a one-hour or two-hour or (at best) one-week seminar to a large group of people whom we don't know and who don't know us. Fortunately, we have discovered that a role play of an actual session between a supervisor and supervisee frequently provides an "Aha!" experience for audiences. If we introduce the role play carefully, place it in context, and have the players analyze their interaction themselves and in dialogue with the audience, we can **demonstrate** the process of reflective supervision. It is rather like a good play, I think. We can **dramatize** a process between people who trust each other and themselves enough to have a conversation in which neither knows the knotty challenges in advance, nor certainly, does either know the right questions beforehand.

I'd say that role playing is teaching in the broadest sense—making manifest things like engagement, relationship, self-reflection, observation. People watching others take on the roles of supervisor and supervisee can **see** democracy, equality. They can think, "This is not what I've been doing or getting. I want this in my life."

Q. *Why do you call role playing a "risky business"?*

A. A role play about the process of reflective supervision cannot be scripted. For a demonstration of a relationship to work, it needs to be spontaneous, meaningful, and authentic. So the role players have to be willing to live more dangerously than we usually do in a public place—it's like getting up to dance when you know everyone else in the room will be watching you. The person who takes the role of supervisee runs the risk that the audience will see her as a novice and remember her that way. The role of supervisor is probably even riskier: You don't know beforehand what you will be presented with, you can't prepare, and all you can do is try to do the best job you can, with nothing to hide behind.

When you give a lecture, people find out how you **think**—what are your ideas? Can you organize them? But you have gotten them together and set them up logically and thoughtfully in advance. In a role play, you have to be willing to let people watch how you **work**. The audience sees your repertoire of responses as the situation unfolds. They can see where you have a ready answer and what gives you pause. In contrast, in our fields, we don't usually have anyone watching our work—except our supervisor.

The level of engagement needed to teach this way seems worth it, but it's also very hard. When you prepare to give a talk by yourself, you do your homework and you end up with a product. You know what you're going to say when you walk up to the podium. With this relational approach, you have to wait for things to unfold. There's always that terrible tension—will we get to something good enough in the time available?

Q. *How did you arrive at the idea of using role play as a way of conveying the essence of reflective supervision?*

A. Those of us who worked on the TASK project from 1988 to 1990 (which tried to identify the elements of training important for all work with infants, toddlers, and their families) became increasingly convinced that reflective supervision is fundamental to all professionals working with the birth-to-three population. In the summer of 1990, the Training of Trainers Intensive Seminar (TOTIS) gave us our first opportunity to teach about what we were thinking. That meant that we had to teach about supervision.

The seminar was five days long, and we were committed to devoting a substantial amount of time to supervision. Two-and-a-half hours on each of the five days: What were we going to do? Since I had responsibility for the supervision section, I hunted

in the literature and, to my amazement, found hardly anything about supervision in infant/family work or in professions that do not have a tradition of reflective supervision. Even in case studies that ZERO TO THREE and others have published, decision-making points are usually almost invisible, and the supervisory process is always totally unmentioned. We realized that we would have to invent what we were going to do. We knew that I couldn't just lecture about supervision and hope to convey what it is. I felt strongly that the supervisory relationship needed to be demonstrated, felt, somehow **lived**, if this was going to work.

Q. *How did you decide to work without a script?*

A. It seemed like the only way to get across the experience and the feeling tone. I have found that something I can offer as a teacher is letting people see me as I am (as in this interview) rather than always having to present a more formal facade. Even though it sometimes costs me dearly in terms of anxiety, I am usually willing to put myself in a position in which people can see how I work and how I feel. That willingness to be exposed, I hope, allows people to identify with someone who is in the position of leader; they can see not only the strengths but also recognize areas of weakness or vulnerability. The student isn't just in awe; she can find her way to a point of connection, which could be something like, "Maybe I'm not so bad. I have feelings like that, too."

Q. *So, then, what did you actually do to set up the role play?*

A. Emily and I talked about it a lot. We knew that we had to make the exchange between the supervisor and the supervisee become the focus, but that it would need an actual case to anchor their interactions. She had the idea of using a real case report; I thought that could work if she would use her background as a social worker to turn that report into process recordings of sessions between the supervisee and the client family. ("Process recording" is a social work term for the worker's written record of an interview, which tries to capture as much as possible of what happened and was said by the individual or family and the worker, as well as the worker's observations and impressions.) We developed an identity for the supervisee, who was to be played by me—basically a less experienced, younger version of my real self. We also added contextual flesh—things like the type of hospital in which I was based, the cast of other characters, and so on.

Q. *Had you learned from role plays yourself, or used role plays in your teaching before?*

A. No. But I thought, this is the one way I think that this material can be conveyed; it **has** to be done. I had recently had some experiences offering brief supervision to people who did not have mental health backgrounds. They would come to the supervisory sessions silent and frightened, because of their prior experiences. Before they could open up, I had to show them that they would be safe, that letting me see what they were encountering would allow me to be of help. I wanted to show the TOTIS participants—a group of more than 50 trainers and supervisors from a whole range of disciplines—that **they** could be safe.

I don't think that I could have tried role play at TOTIS without support from ZERO TO THREE staff, especially you, Emily at that time. You were dubious initially, but the fact that I was able to talk you into using the role play strategy gave me confidence that we could pull this off. I had a lot of respect for your judgment, and once you were convinced, you never waffled. Your confidence boosted my sense that this was the right strategy. Taking a public risk, like experimenting with role play that first time, is a very tricky thing for people (especially women, perhaps) to do in the absence of a support group.

Q. *In TOTIS, you took the role of supervisee in the series of role plays over five days. Since then, you have been taking the role of supervisor, and a co-presenter has taken the role of supervisee. Why did you change the format?*

A. Originally, we wanted to give volunteers from the "audience" experience "being" a supervisor—to try out the role and to get feedback...I still think that could work in another type of teaching situation, either in

privacy or with a very small group of people who have time and opportunity to know and trust each other. The person taking the role of supervisee needs to be able to say to the person "being" the supervisor, "When you did that, it made me feel awful...." But in a large and diverse group, it's not possible to develop enough trust for that much exposure and, of course, I didn't want to point out the vulnerabilities of volunteer participants. So even though what we did at TOTIS ended up having a lot of impact on many of the attendees, in planning for future role plays we wanted to be in the position of being able to explore why the supervisor did whatever she did. That meant we needed the supervisor to be played by someone who agreed in advance to what she was getting into. That meant that I had to take the supervisor role.

Since TOTIS, we have found that when two experienced presenters do the role play, **we** take the risks. We are trying to be spontaneous and authentic, being ourselves fully and letting people see who we are. The person taking the role of supervisee usually tries to be his or her "younger self"—not a different person—and the person taking the role of supervisor—it's been me each time so far—does the best she can! The point is for the audience to get a glimpse of the **inside** of a relationship—it's pretty powerful, judging by the feedback we've gotten.

In the context of a larger presentation about supervision, we can also plan all the different pieces we need to include to set the role play in context and plumb its potential—the framing, the analysis, the dialogue with the audience—and we can prioritize the time available, whether we have just two hours or a full week.

Q. *What would you say to others who may want to use this kind of role play to teach supervision?*

A. I'd say that you need a willingness to take some risks, and you need support. It's like becoming a parent or learning a new profession—all involve risk and require support. For instance, there were a couple of times when I came pretty close to giving up on the role play approach, and it was your vision, Linda, based, I guess, on how you had seen it work before, that helped me get back to it.

Role playing is not something that people do in public every day, but neither is lecturing. Professionals who are trying to expand their capacities need support, guidance, critique, and validation. Of course, these things are what supervision offers. I guess I'm saying that we need support throughout our careers in order to keep growing, to keep expanding our capacities. It's important to get critiqued after the session about how the total session worked, by people who you know will tell you tactfully not only what worked but also what didn't. It's like getting supervision on your pedagogical approach.

Q. *You mean you get formal feedback about each teaching session, beyond the evaluation forms filled in by the audience?*

A. Yes! Using a new teaching approach about material that we were just developing mandated that we do "post-mortems" on every session. Emily and Linda, you have both been extremely helpful, and so have other faculty members at the various forums in which we did a version of the supervision role play. Gordon Williamson, who played the role of my supervisee at City TOTS, talks about getting serious about teaching **methods**; along with his comments, the feedback that I've received on the role play sessions has influenced my recognition that **all** of the teaching we do ought to get that sort of candid feedback from our peers. Just because we know something about the content and even the process of our field doesn't necessarily mean that we are skilled at getting it across when we teach. Hopefully, this feedback leads to comments **after** a session as well as supportive planning **before** the next one. That way, there's a chance that it can change and improve over time.

Q. *Might this approach end up with other plans or products, besides the teaching per se?*

A. Sure. For instance, sometimes it becomes clear that new materials are needed. That's what happened during and after the first teachings we did on supervision at TOTIS: We realized that we needed written materials about supervision specifically geared

to the zero-to-three cross-disciplinary approach. So, with support from the David and Lucile Packard Foundation, we convened a work group on the topic; that's how *Learning through Supervision and Mentorship* (ZERO TO THREE, 1992)—sometimes known as "the yellow book"—was born.

Q. *What happens next?*

A. I'm excited to see how people will use the videotapes of the pre-institute seminar on supervision that Linda Gilkerson and I gave at ZERO TO THREE's December, 1994 National Training Institute. The tapes include what we did together that day: a general introduction to reflective supervision, a 20-minute role play, and analysis and discussion. We expect that people at various levels of training and experience will use the video in different ways for different purposes. Some trainers or program directors can use it to "convey the essence" of reflective supervision to a group. Some people may want to turn off the sound and just look at our facial expressions and body language. Others may want to spend a lot of time discussing one or two specific exchanges between the supervisee and supervisor. We hope that people will use the videotapes and *Learning through Supervision and Mentorship* together.

I also hope that other trainers will be emboldened to try unscripted role plays as a way of teaching supervision. There's a special excitement to teaching this way, watching the live interaction unfold, and discussing what people saw and felt. Maybe the riskiness contributes to the excitement—it's like watching tightrope walkers perform without a net!

Reference

Fenichel, E. (Ed.) (1992) *Learning through Supervision and Internship to Support the Development of Infants, Toddlers, and Their Families: A Sourcebook*. Arlington, VA: ZERO TO THREE National Center for Clinical Infant Programs.

On supervision and observation:

The process of supervision is serious-minded, rich, shared attention to the nuance of multiple observations. In the end, observations are all we have to operate from in the living moment with another human being.

What does it mean to observe? It means to **really** notice. To notice nuance about feelings and to follow them. To become aware of contradictory feelings (like love and hate of the same person) as you discern the pattern of what the person is showing you and saying to you. To notice patterns from past relationships—patterns that the patient brings from past relationships, and that the supervisee brings from **her** past relationships. We reflect on maladaptive patterns and how they interfere. As we do this together, we assist the supervisee in gaining the courage to acknowledge that which is deemed unutterable in ordinary social interaction. This work is done on many levels. So we help the supervisee to observe:

- the child, each parent, each person connected with the family, their home environment, and their community context.
- the supervisee's behavior, feelings, and history; her theoretical and practical knowledge, what she knows and what she does not know.
- the relationship between the supervisor and the supervisee.

It is not enough to just listen to the words. Words are a small piece of what a person brings to an encounter. What do his eyes tell you? What does the cast of his mouth tell you? How does he move his body? We all take in information on multiple levels and we need to open ourselves viscerally to what the experience is. That helps us to come to know intimately what the patterns of this particular person are and, gradually, what they may become.

In supervision, we share and reflect on all these multidimensional and interrelated observations. We consider the observations together, empathetically. Feelingly, we use the templates of our theories, experience, and histories to analyze, organize and help us to plan the next mini-step as we delineate the possible goals.

Being able to bear **not** knowing is a large part of clinical work, and of the supervisory relationship. And having the confidence that together, gradually, we will find our way—that very often the answers lie embedded in the process of the work, and of supervision. We offer that process collaboratively and regularly.

The process of supervision involves multiple steps: the observation of the multiple dimensions; remembering all of them; and reporting them to the supervisor; considering them; analyzing and organizing them; comparing them to prior experience and knowledge about developmental theory; discovering short-term objectives which guide how we choose what we do or say. Gradually, over years, this process **goes inside** the supervisee to become her art and science in working with families and children.

Scenes from supervision

The dialogue that follows is excerpted from the role play videotaped at ZERO TO THREE's 1994 National Training Institute.

Scene One:

Supervisor: I need you to tell me so I can picture it... on the last visit the dad opened the door, and then he went to the kitchen and you were just standing there, and the mom was on the couch, and Jimmy was in the room, and you entered right in. So the dad says "hello" to you, he moves away, and you then...?

Supervisee: Usually I try to connect with them all...I don't even know how to do that now...I tried to make a connection to Mrs. Emery, but she was scary, because she had no expression...it was like she was vacant. She knew I was there... she did not respond to me. She was hollow. It was scary to me when I looked at her and saw that. I don't remember what she did say, and Alan, the baby, started to cry—he began to cry and Jimmy was over there pulling on her clothes and I was kind of frozen at that moment.

Supervisor: What were you feeling?

Supervisee: I was feeling helpless, and I didn't know who to look at.

Supervisor: You must have been tempted to pick up Alan and take over!

Supervisee: Yeah, you know what? I freeze when I don't know what to do...I freeze. Jimmy was close by, so I just kinda waited a moment and said, "It sounds like Alan is upset."

Supervisor: In a way you were kind of like the mom. She was kind of frozen on the couch, like you. It was something familiar to you—it is not like you have never gotten frozen before. Something about her being a solid mass like that and being so unresponsive evoked something similar in you, something from your experience bank. You met her where she was, you mirrored her in some way...

Supervisee: Yeah (laughs). I think I'm laughing because I'm thinking how that could be helpful (laughs). Well, I guess my question is: how can I be helpful? Supervisor: I don't know the answer to how to be helpful yet—even how to be helpful to you—but one thing I think I am seeing: Your feelings are very available to you, and your feelings really let you get the heaviness of what this mom has experienced.

Supervisee: But it feels like I was feeling nothing, like I was stopped in my tracks!

Supervisor: Maybe you have gone through some processes since the visit, because what you're bringing to me (I feel, anyway) are very delineated feelings of being overwhelmed, feeling helpless, caring a lot, and wanting to do a lot, but feeling like you don't know what the hell to do. Supervisee: This is registering for me that this is serious. I think I got that.

Supervisor: What were you feeling about yourself in relation to how serious this is?

Scene Two:

Supervisee: The mother seems de-- it doesn't feel like I should say she's "depressed." How do I **know** that?

Supervisor: You're feeling it in your own body. She's communicating it right into your gut. You came in here behaving helpless, feeling helpless, feeling heavy and helpless, and that is an exact mirror of what she is feeling. Your body, your reactions are mirroring, they are an instrument that is capable of mirroring what it is that other people feel.

Supervisee: But that seems so subjective.

Supervisor: Well, I'd say that it is not possible to make a diagnosis without being able to sit in your seat—as someone who knows something about theory, classification, but really sitting in the other person's seat (or, in this case, lying on their couch)—and getting in there and having some notion of what it feels like to be in that body.

Supervisee: I can see it, but I was hesitant to say it. But I think she is very depressed. Saying that, I don't feel I know what to do about it. I don't know where to go with that.

Supervisor: Diagnosis doesn't necessarily tell you what to do. I hope that together ... you know a lot of things I don't know about. I do know about diagnosis, at least some kinds of diagnosis, about emotional and social things. I don't know much about physical diagnosis stuff, and I don't know much about working in hospitals like you do. So we make a good pair, you know, you and me. And I hope, I really hope we can begin to find our way to building on what we each know and then feeling some sense of entitlement.

Supervisee: Wow.

Supervisor: So I want to give you a sense of entitlement to what you already know really very well.

Supervisee: It makes me feel better to even think about sharing this case in any way. It's not only me out there. We are working as a team in relationship to this family.

Supervisor: Let's see whether in the time we have left we can figure out—

Supervisee: What to do?

Supervisor: Well, I wouldn't say that much. I don't think we can figure out what to do in the big sense. What I would like to figure out is, maybe list some things that are possible to do, but then figure out what you are going to do in the next visit in terms of just taking the next step, which will help us then find the next one after that.

9

New Roles For Parents

Evelyn Hausslein

This essay is reprinted by permission from the *Early Childhood Bulletin*, which is prepared by the staff of the Federation for Children with Special Needs who participate in the National Early Childhood Technical Assistance System (NEC*TAS), which is funded through the U.S. Department of Education's Office for Special Education Programs (OSEP), Early Education Program for Children with Disabilities, under contract #HS-91-01-1001 awarded to the Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill. Grantees undertaking such projects under government sponsorship are encouraged to express their judgment in professional and technical matters. Points of view or opinions, therefore, do not necessarily represent the Education Department's position or policy.

One of the principles of family-centered care set forth in the book *Family-Centered Care for Children with Special Health Care Needs*, is **"Facilitation of parent/professional collaboration at all levels: care of an individual child; program development, implementation, and evaluation; and policy formation"** (Shelton, Jeppson, & Johnson. 1987, p. 71). Parents who are serving on Interagency Coordinating Councils (ICCs) for their state early intervention programs already are active in policy formation. Another important way for parents to foster parent/professional collaboration is by participating in preservice and inservice training opportunities for professionals. This article outlines some issues to consider in thinking about how parents can contribute most effectively to training and suggests some resources for assistance in developing a curriculum for training.

The first questions parents must answer when asked to help with training are "What role am I being asked to play? Am I being asked to give advice on the contents of the curriculum, to participate in delivering the training, to review a curriculum from my perspective as a parent, or to observe a training session and evaluate the teaching style or the content?"

Sometimes a curriculum developed by teachers and trainers is offered to a few parents or a parent advisory board for review. The most important expertise you have to offer is your firsthand experience as a parent. Tell how the tone and approach impress you as a parent—useful, offensive, informative, etc. Give specific examples of how the proposed training would have helped or hindered the services and support given to your family; how it would have helped or hindered the providers who worked with you; and how it would have enhanced or discouraged your participation as an equal member of the planning team.

Review the curriculum from the perspective of whether or not it is consistent with and furthers the ideas of family-centered care. In addition to the principle of family participation mentioned in the introduction, it may be helpful to consider other principles cited in the same book:

- Is there a recognition that the family is the constant in the child's life while the service systems and personnel within those systems fluctuate?
- Is the view of families as equal partners and collaborators with professionals upheld?
- Are family strengths recognized and their individuality respected? (Shelton et al., 1987)

Participating in training

While parents have much of value to con-

Evelyn Hausslein, Early Childhood Specialist, Federation for Children with Special Needs, Boston, Massachusetts

tribute to the entire range of discussions about children with special needs, one of the most important contributions they can make is to add a context of reality to policy and program discussions. By telling the story of their child and family, parents can make abstract points memorable by adding the richness of real examples. If services are to be truly family centered, opportunities for professionals to learn directly from parents are critical. Families' stories, their firsthand experiences about what it is like to be a parent of a child with a disability and how the work of early intervention affects their family, focus the training on consumers, i.e., families. These stories help create a vision of *why*, not just how and what, services are provided.

To be most effective in telling your story, it is important to help the specific topic to be discussed and to think about the principles or issues you would like your story to illustrate. Once you have decided the issues within the topic area that are important to you and your family, craft your story by drawing on specific incidents that illustrate them. Talk about when things went well and what specifically made them go well, as well as when things did not go well and what you wish had been done differently. Be specific. To make your story come alive, bring along a picture of your family to pass around (or you can have an overhead transparency made of any photo at a copy store!).

As parents gain experience, many are asked to participate beyond telling their story. It is becoming more common for parents to join the faculty of programs and colleges providing trainings, modeling the partnership and collaboration that is the underlying philosophy of Part H. Now parents are developing and delivering curricula on a wide range of topics related to children with special needs. While they use their own and other families' stories to illustrate key points, there is a structured curriculum. When participating in this way, consider your experience as a parent coordinating your child's care and managing a household, as a member of your community, and as a person with work skills and knowledge.

You also may be invited to participate as an observer of the training. In this role you are not only a learner, but you also will give feedback to the trainers as to the usefulness and effectiveness of the training. Think about how the training did (or did not) promote a family-centered approach to support and services, and whether or not parents collaborated in the design and delivery of the presentation. In this role it is good to comment as specifically as possible on what was particularly good and what recommendations you would make for change. Did the audience have an opportunity to respond, to ask questions, and to contribute their own experiences? Was a parent participating in the training and was it clear as to the importance of the parent's contribution?

It is always important to remember that family-centered service delivery is a very new concept. While the principles are embodied in Part H legislation, they are far from being part of business as usual. New professionals seldom are taught these principles and their implications as part of their formal training; parents can contribute to their ongoing learning.

Reference

Shelton, T.L., Jeppson, E.S., & Johnson, B.H. (1987). *Family-centered care for children with special health care needs*. Washington, DC: Association for the Care of Children's Health.

10

Learning Together: A parent's perspective

Pat Hughson

Editor's note: In order to live up to its name, a Forum for Educators and Trainers of Infant/Family Personnel must provide opportunities for dialogue among all those engaged in this work. To ensure that the perspectives of parents would be represented in Forum discussions, ZERO TO THREE contacted the Maryland-based Institute for Family-Centered Care for help in facilitating parent participation. Pat Hughson agreed both to participate in the Forum and to share her reflections on the experience.

I am the parent of two children with special needs. My son, born at 24 weeks gestation, weighed one pound eleven ounces at birth and is challenged with mild cerebral palsy, chronic asthma, and visual perceptual delay. My son receives physical therapy and speech therapy and nebulizer treatments three or four times a day. He is now five years old and is a die-hard Power Rangers fan. My daughter, born at 26 weeks gestation, weighed two pounds, two ounces at birth and has speech and language delays as well as asthma. My daughter receives speech therapy and occupational therapy, and is on medication to control her asthma. My daughter has the general attitude of every two year old—that the world is hers, and she is not going to share it.

Professionally, I divide my time between the Institute for Family-Centered Care, where I am the Family Information Specialist, and the Montgomery County Infants and Toddlers Program, where I serve as the Family Support Network Coordinator. I also operate a phone support network from home for parents of premature children. This network links veteran parents to parents who are new to the neonatal intensive care unit. Families who have children with other special needs have also called my network for support and resources.

One of my functions at the Institute is to work as part of a parent/professional team that provides training and technical assistance to hospitals throughout the country. We review their policies, programs, practices, and facilities and share information about family-centered care and innovative efforts undertaken by other institutions. As a parent whose children have had extended hospital stays, I am able to offer my insight about how families experience care; how they might view written materials the hospital provides; how visiting policies are likely to affect their participation in care; and how they might react to the facility itself. At the Family Support Network, I create opportunities for families of children with special needs to meet each other through social events and to hear about local workshops and support and advocacy groups.

My experience at the ZERO TO THREE Forum

Although I was one of a small number of parents who attended the Forum, I felt comfortable participating. Families don't wear stamps on their heads, so unless I wore my name tag which designated me as a parent, I don't think people distinguished me from anyone else there. My goal was to become more proficient in training professionals and families and to share my perspectives on training. There were times when I found myself the parent learner; other times the educator/supporter of professionals. In a role play on supervision, I witnessed the struggle of a professional who was trying to put a past experience with a family in perspective. Early in her career she had given a family a diagnosis about their child in a way that she felt was inappropriate. I stood up and told her that she should keep in mind that she is only human and that families realize this, too, about professionals.

Pat Hughson, Family Information Specialist, Institute for Family-Centered Care, Bethesda, Maryland

As I participated in small work groups, the question came up, "How can I work better with families?" The operative word is **with**. In each group, I shared my perspective on working in new ways with families. I talked about the language that professionals use in describing families.

> *Words can reflect attitudes of respect or disrespect, inclusion or exclusion, judgment or acceptance. Language choices can facilitate or impede communication. Taking care with language enables professionals to examine their own thoughts and attitudes and helps them build collegial, open, and respectful relationships with families. . .*
>
> *When differences arise between families and professionals regarding the care of an individual child, describing parents and other family members as "non-compliant," "uncooperative," or "difficult" implies that professionals make the decisions and give instructions that families must follow. Referring to parents and other family members as "partners," "colleagues," "joint decision-makers," or "experts about this child," acknowledges that families bring important knowledge and insight, and that families and professionals form a team.*
>
> *Labeling families as "dysfunctional," "in denial," "overprotective," "uninvolved," or "uncaring" implies a judgment that may not incorporate a full understanding of a family's situation, reactions, or perspectives. Using words like "coping," and describing a family's reactions with care and respect, leaves room to build a more complete and appreciative understanding of families over time.*
> (Hanson, Jeppson, Johnson, Thomas, and Hall, 1994)

In family/professional collaboration, it is often helpful to ask families directly what they like to be called. Some families like the term "veteran parent" or "parent-professional."

In the many conferences I have participated in, participants have often talked about the differences between families and professionals. We have not always articulated what we have in common. We are all human, and based on that, we must build lines of trust and communication, in order to move toward approaches that are more family-centered.

Families are advisors, consultants, liaisons, mediators, policy makers, advocates, movers and shakers. Families are professionals in a different way—we live the reality. The reality helps us to design the model for working in collaborative ways.

This brings me to a story that was told to me by a parent who participated in the Forum. This parent has three children, the youngest of whom is a toddler with Down syndrome. After one of the work groups, a professional who had participated in the same group said, "You sound like a professional." The parent replied, "I am," and

TIPS FOR RECRUITING FAMILIES

Ask other families who are already involved if they have a friend who might be interested in participating.

- Contact local or statewide parent-to-parent organizations.
- Ask providers to help identify families.
- Post notices in appropriate languages on bulletin boards in waiting areas in clinics and in hospital emergency rooms.
- Post notices in appropriate languages on bulletin boards at educational, recreational, and social service programs serving children and families.
- Develop radio and TV public service announcements in the language of the communities you are trying to reach.
- Place a story in community newspapers.
- Use "key informants"—people in the community who are knowledgeable about children with special health care needs and are a link to other families and family groups.
- Ask community and church leaders.
- Send notices to social and cultural clubs in the community.
- Place posters in community locations—at large employers, churches, housing projects, gas stations, social service agencies, and kindergarten registration.
- Send a letter home with school children.

Source: Jeppson, E. & Thomas, J. *Essential Allies: Families as Advisors* (1994) Institute for Family-Centered Care, Bethesda, MD.

elaborated. (This parent sits on local and state councils for disability issues, edits a family support group newsletter, participates in all of her child's Individual Service Plan activities, presents at conferences, performs advocacy and support activities for other families, holds a full-time job, and runs a successful home-based business, as well as being a wife and mother.) The professional went on to explain her comment. It was an awkward moment even though the parent believed that the professional was complimenting her expertise, ability, and knowledge. This parent brought and integrated a wealth of life experience to her role as a parent of a child with special needs.

Stereotypes of parents fail to recognize that we are multi-faceted, and that we have talents, resources and commitment to bring to the process. Unfortunately, parenting is not recognized as a profession. Further, we are constantly struggling for the "right way to say it." This is a difficult task for both professionals and families to undertake. Let the family define the language that best fits their circumstances.

One of the most frequent questions that I was asked at the Forum was how to identify and support families in family/professional collaborative activities. Helpful guidance is offered in *Essential Allies: Families as Advisors* (Jeppson and Thomas, 1994), a new publication from the Institute for Family-Centered Care.

At the Institute for Family-Centered Care, my colleagues and I often hear from professionals about how powerful it is to learn from families. We hope that more opportunities will become available, at the national as well as at the local level, for families and professionals to learn together.

References

Hanson, J.L., Johnson, B.E., Jeppson, E.S., Thomas, J., & Hall, J.H. (1994). *Hospitals Moving Forward with Family-Centered Care.* Bethesda, M.D: Institute for Family-Centered Care.

Jeppson, E. & Thomas, J. (1994). *Essential Allies: Families as Advisors.* Bethesda, MD: Institute for Family-Centered Care.

CONFERENCES AND MEETINGS: MAKING FAMILY PARTICIPATION SUCCESSFUL

1. Identify *all* the costs associated with family participation. Include travel, transportation costs to and from airport, hotel, meals, registration fees, child care, and any other incidental expenses.

2. Cover expenses up front. Purchase tickets ahead of time, provide cash for family per diem expenses, create a master account at the hotel using your credit card. Explain what the per diem will and will not cover. If there are expenses you will not cover (e.g. movie rentals and mini-bars in the hotel room), tell families ahead of time.

3. Plan ahead. Airplanes, taxis, and hotels are not set up to be flexible. Therefore, you must be creative, thorough, and vigilant in planning so that families are neither excluded nor embarrassed when negotiating these systems.

4. Develop a policy for honoraria or consulting fees for families. If professionals are being paid for their participation, families should be as well. If families are asked to speak at conferences they should receive an honorarium.

5. Provide thorough preparation for families prior to the meeting. Send information about the meeting and families' roles. If materials must be reviewed, send them in time. Review families' understanding of the information and what is requested of them. Provide complete logistical information—how to get from the airport to the hotel, who to contact and how to contact them in case of problems.

6. Communicate by telephone and by regular mail. Most family members do not have easy access to fax machines, e-mail, or Federal Express. If you request information from families (e.g. registration materials, speaker needs), make sure to allow ample time for families to respond by regular mail or give them your Federal Express number.

7. Think of every single thing that could go wrong and plan for it.

Source: Jeppson, E. & Thomas, J. *Essential Allies: Families as Advisors* (1994) Institute for Family-Centered Care, Bethesda, MD.

11

Curricula for Infant/Family Training

Adaptive Switch Technology Birth Through Five Years: A Curriculum Guide.
Kathy Bollbach and Alan Berger, 1990.
Target audience: Professionals and paraprofessionals.
Description: Description of ways in which Switch adapted toys, puzzles, and appliances can enhance learning in children with and without motor impairments. Activities and goals correlated with the HELP (1979) and Carolina Curriculum (1986).
Ordering information: 71 page curriculum guide is available for $19.95 plus shipping and handling from SteppingStone Day School, c/o Maureen Vecchione, 77-40 Vleigh Place, Kew Garden Hills, NY 11367, tel. (718) 591-9093 or fax (718) 591-9499.

Children With Special Needs In Family Day Care: A Handbook of Approaches and Activities for Family Day Care Home Providers.
Beatrice de la Brosse, 1987.
Target audience: Inservice, paraprofessionals.
Description: Curriculum which focuses on how children learn. Offers educational approaches and techniques in working with children with special needs.
Ordering information: 158 page curriculum (available in Spanish) can be ordered for $22.00 plus shipping and handling from El Centro de Rosemount, 2200 Rosemount Avenue, Washington, DC 20010, tel. (202) 265-9885.

Coping Training Topics.
G. Gordon Williamson, PhD, OTR, Andrea C. Quigley, MS, 1993.
Target audience: Inservice, professionals and paraprofessionals, multidisiplinary.
Description: Document designed as introductory material to the Coping Project with available training topics and procedures. It is sent to potential trainees to help in the design of the training sessions.
Ordering information: 12 page booklet available at no cost from The COPING Project, Pediatric Rehabilitation Department, John F. Kennedy Medical Center, 2050 Oak Tree Road, Edison, NJ 08820, tel. (908) 548-7610 or fax (908) 548-7751.

Curriculum Compendium.
Linda Flynn, Linda Fredrick, Dalice Hortzberg, H. Lewis, (Eds), 1994.
Target audience: Preservice and inservice, faculty and trainers.
Description: A collection of comprehensive, critical reviews of 22 of the best curricula in the field of birth-three. Faculty and trainers can use these complied reviews to accrue knowledge of available curricula to support their teaching and training activities. Another edition will be available in early 1995 with 5-10 new curricula as they are identified.
Ordering information: 80 page document free within Western Region; $5 plus shipping and handling outside Western Region from Western Region Faculty Institute for Training, JFK Center for Developmental Disabilities, University of Colorado Health Science Center, 4200 E. 9th Avenue, Box C-234, Denver, CO 80262, attn. Barbara Schoen, tel. (303) 270-6528 or fax (303) 270-6844.

Exploring the World of Infants & Toddlers.
Brenda Weitzberg, 1992.
Target audience: Preservice and inservice, professionals and paraprofessionals.
Description: Developed by Friends of the Family, it addresses infant/toddler development and practical methods for working with parents of children birth to three. Over 1000 service providers in Maryland have participated in this 20-hour training. Topics include the newborn, attachment, separation, parent-infant relations, the older infant, temperament, the toddler, discipline, toilet learning, language development, developmental warning signs, working with parents, self-esteem, and respectfully caring for infants and toddlers.
Ordering information: 161 page manual available for $20.00 plus postage and handling from Friends of the Family, Inc., 1001 Eastern Avenue, 2nd Floor, Baltimore, MD 21202-4364, tel. (410) 659-7701 or fax (410) 783-0814.

Medically Fragile Infants and Toddlers: An Interdisciplinary Training Curriculum.
Hal Lewis, Ph.D., 1994.
Target audience: Preservice and inservice, professionals, interdisciplinary.
Description: Comprehensive curriculum, with extensive content-oriented outlines, focused on medically fragile infants/toddlers. Organized in seven modules, which can be used individually or as a total package.
Ordering information: 300 page curriculum available for $15 plus shipping and handling from JFK Center for Developmental Disabili-

ties, University of Colorado Health Science Center, 4200 E. 9th Avenue, Box C-234, Denver, CO, 80262, attn: Barbara Schoen, tel. (303) 270-6528 or fax (303) 270-6844.

Montana Child Care Provider Handbook and Assorted Training Materials.
Child Care Resources, 1992.
Target audience: Preservice and inservice, professionals and paraprofessionals.
Description: A generic training tool designed to assist regulated child care professionals. Offers practical training for the business of child care. Style is chatty and inviting. Currently being used statewide as an orientation tool for new providers by the Montana Resource and Referral Network.
Ordering information: 90 page handbook available for $10.00 plus shipping and handling from Child Care Resources, 127 East Main Street, Suite 314, Missoula, MT 59802, tel. (406) 728-6446.

Opening Your Door to Children: How to Start a Family Day Care Program.
Modigliani, Reiff, Jones/NAEYC, 1987.
Target audience: Preservice and inservice, professionals and paraprofessionals.
Description: Introduction to family day care. Helpful suggestions for planning, preparation, and improving family day care service. Answers questions typically asked by people considering family day care.
Ordering information: 69 page curriculum available for $3.50 plus shipping and handling from National Association for the Education of Young Children, 1834 Connecticut Avenue, N.W., Washington, DC 20009-5786, tel. (202) 232-8777 or (800) 424-2460.

Parent Partners Listener Training.
Marian H. Jarrett, Ed.D., 1994.
Target audience: Preservice and inservice, NICU staff and parents of NICU graduates.
Description: A 10-hour program to train volunteer parents to provide one-to-one support to families experiencing a premature birth, critically ill newborn or a newborn loss. The step-by-step Trainers Manual contains training activities, listening exercises, handouts for parent trainees, resource lists, and sample letters and forms. It describes how to organize a Parent Partners Program in a hospital nursery.
Ordering information: Prepaid orders of the 270 page Trainers Manual available for $25.00; the 104 page Parent Training Manual available for $10.00, both plus postage and handling, from George Washington University DTPSE, Parent Partners Program, 2201 G Street, NW, Suite 524, Washington, DC 20052, tel. (202) 994-6170 (202) 994-3365.

Perinatal Support Groups Facilitator Training Manual.
Judith Rosenberg and Deborah Lee, 1992.
Target audience: Preservice and inservice, professionals and paraprofessionals, nursing, social work, health education, parent education, community health promotion.
Description: Reference manual providing a step-by-step approach to creating support groups for pregnant women and new parents. Describes in clear, simple terms a well-tested model used throughout California and Oregon to create groups for over 4000 low-income women in community clinics, non-profit agencies, teen parent programs and health departments. More than half the facilitators trained were women of color leading groups in their own communities. The manual includes many examples of applications of this model by the facilitators.
Ordering information: 100 page curriculum available for $15.95 plus $3.00 shipping and handling from Support Group Training Project, 484 Lake Park Avenue, #105, Oakland, CA 94610, tel.and fax (510) 649-3084.

The Program for Infant/Toddler Caregivers. California Department of Education, Child Development Division, and Far West Laboratory, Center for Child and Family Studies, 1990.
Target audience: Preservice and inservice, professionals and paraprofessionals.
Description: A comprehensive training system for providers of care to infants and toddlers in both family child care and center programs. Videos, the centerpiece of the training system, are complemented by video magazines, caregiver guides, trainer's manuals, and various other written materials. Except for the trainer's manuals, every component of the training system can stand alone as a training tool. The manuals provide suggestions, lesson plans, and additional materials to assist in using the Program's videos, guides, and other materials in training. The four training modules include: Social-Emotional Growth and Socialization; Group Care; Learning and Development: and Culture, Family, and Providers. Module training institutes are conducted by Far West Laboratory and the California DOE. Certified trainers available across the country.
Ordering information: Modules ranging from $130–260 each and 30–60 minute videos which cost $65.00 each are available from the California DOE, Bureau of Publications, Sales Unit, P.O. Box 271, Sacramento, CA 95812-0271, tel. (916) 445-1260 (ordering) or (916) 332-6233 (information).

Resource Mothers Curriculum Sourcebook.
INMED for the National Commission to Prevent Infant Mortality, 1993.
Target audience: Preservice and inservice, paraprofessionals, maternal and child health.
Description: Designed to be used with the Resource Mothers Handbook. 3-ring binder contains curriculum with interactive teaching tools

for trainers of home visitors. Topics ranging from pregnancy, parenting and child development to self-esteem, problem solving and community advocacy are presented through role plays, games and didactic training methods. Contains information on adult learning and literacy skills, as well as principles of empowerment and cultural competency.
Ordering information: 350 page curriculum available for $35.00 plus shipping and handling from MotherNet, c/o INMED, 45449 Severn Way, Suite 161, Sterling, VA 20166, tel. (703) 444-4477 or fax (703) 444-4471.

Training Workbooks.
Zeitlin, S., & Williamson, G.G.
Target audience: Inservice, professionals and paraprofessionals, multidisiplinary.
Description: Adapted from Coping in Young Children: Enhancing Resilience and Adaptive Behavior, 1994. Workbooks developed for each training topic(s) and designed to provide structured note taking and information on the coping model, observing and recording transactions, rating and analyzing the Coping Inventories and developing plans for intervention. The workbooks also include appendices with detailed information on case studies, the coping process model, and intervention strategies based on coping style. The books are designed to complement and support the training session and are not designed to be used outside the training.
Ordering information: 25-35 page workbooks, depending on topic, available for $25.00 each, plus shipping and handling, from The COPING Project, Pediatric Rehabilitation Department, John F. Kennedy Medical Center, 2050 Oak Tree Road, Edison, NJ 08820, tel. (908) 548-7610 or fax (908) 548-7751.

Vision Training with the Computer.
Kathy Bollbach, 1994.
Target audience: Inservice, professionals and paraprofessionals.
Description: Manual addresses vision development including awareness, attention, ocular-motor skills, eye-hand skills and perception. Each area has accompanying long term goals and short-term objectives with recommended software to develop visual skills. This manual is intended to augment traditional vision training.
Ordering information: 70 page manual available for $19.95 plus shipping and handling from SteppingStone Day School, Inc., 77-40 Vleigh Place, Kew Garden Hills, NY 11367, tel. (718) 591-9093 or fax (718) 591-9499.

When Children Soar With The Wind: The I.D.E.A.L. Child Care Curriculum.
Sandra Petersen, Jo Koehn, et al, 1994.
Target audience: Preservice and inservice, professionals and paraprofessionals, particularly child care providers and their trainers.
Description: A comprehensive curriculum aimed at helping child care providers develop the knowledge base, skills, and attitudes necessary for successful inclusion of young children with disabilities in community child care settings. Comprised of thirteen modules including topics such as an overview of disabilities, working with families, building relationships, understanding behavior, and adapting the learning environment. Cost available fall 1994.
Ordering information: Available from Early Childhood Initiatives, Colorado Department of Education, 201 East Colfax, Denver, CO 80203, tel. (303) 866-6706 or fax (303) 866-6662.

12

Videotapes for Training

Selected by Margie Wagner

Assessment

Conducting an Infant Mental Health Assessment (58 min.)
Presents a discussion of the methods used to elicit material from families regarding the nature of their relationship with the baby and the etiology of the breakdown in their bond with the baby. Vignettes of interviews with families are used to demonstrate how information is sometimes offered by way of parent-infant interaction or by way of stories or behavior patterns that *appear* unrelated to the questions at hand. Suggestions are offered about how to organize material for a report. This tape is intended principally for use in professional training. Produced by Michael Trout, Director; the Infant-Parent Institute, Champaign, IL. 1986. Purchase $150.
Available from
Child Development Media, Inc.
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401-0933
Tel: 818/994-0933
FAX: 818/ 994-0153

First Years Together: Involving Parents in Infant Assessment (19 min.)
This video is based on the experiences of parents and professionals who participated in First Years Together, an early intervention program for high risk infants and their families. The staff of First Years Together have developed a model assessment process which recognizes the concerns parents bring to an evaluation of their infant—the infant's worrisome start as well as their own questions and concerns about their ability to parent. The video demonstrates the significance of involving parents in infant assessment as an opportunity for intervention, support and education. In both formal and informal assessment situations the needs of parents can be addressed as well as the needs of the infant. Designed for professionals in mental health and health-related fields and for families whose infants were born prematurely or with conditions requiring follow-up.
Produced by Project Enlightenment, Wake County Public School System, Raleigh, NC. 1990. Purchase $65.
Available from
Child Development Media, Inc.
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401-0933
Tel: 818/994-0933
FAX: 818/ 994-0153

Is My Baby OK? (27 min.)
This video addresses what all parents should know about their infant's physical development—especially normal movement capabilities. It helps parents to recognize potential warning signs that could be indicators of a movement disorder. Also available for professionals: Early Infant Assessment Redefined (29 min). Produced by Pathways Awareness Foundation. 1993. Purchase $9.95.
Early Infant Assessment Redefined $24.95.
Available from
Pathways Awareness Foundation
123 North Wacker Drive
Chicago, IL 60606
Tel: 800/ 955-2445

Transdisciplinary Arena Assessment Process: A Resource For Teams (37 min.)
This videotape demonstrates a six-step family-centered, transdisciplinary approach to arena assessment and IFSP development. An accompanying Viewing Guide provides an overview of the transdisciplinary approach, a summary of the six steps of the process, and supporting activities and supplemental

materials. Produced by Child Development Resources. 1989. Purchase $149.95.
Available from
Child Development Resources
PO Box 299
Lightfoot, VA 23090
FAX: 804/564-0144
Tel: 804/565-0303

Child care

Floortime: Tuning Into Each Child (35 min.)
In this staff training/parent orientation program, Stanley Greenspan shows how to "tune in" to the individual needs of children and how help them develop emotionally, socially and cognitively. He teaches how to recognize each child's interests, ideas and feelings through interactive play. This video, filmed in early childhood settings, is accompanied by a 48-page professional guide with ideas and activities; teacher-parent reproducibles; a full-color wall chart, "Children's Emotions: How They Develop"; and Greenspan's "How Emotional Development Relates to Learning." Produced by Scholastic Early Childhood Division. 1990. $74.95.
Available from
Scholastic Inc.
PO Box 7502
Jefferson City, MO 65102-9968
FAX: 314/ 635-5881
Tel: 800/ SCHOLASTIC

Health, Safety and Nutrition from *CARING FOR INFANTS AND TODDLERS* (30 min.)
This tape recognizes that quality infant and toddler child care begins with protecting and promoting the health, safety and nutrition of children. The environment must be safe for children, but still provide for their need to explore and discover. Caregivers must adopt and model practices that prevent the development and spread of disease and need to achieve a careful balance between meeting the children's nutritional requirements, respecting their individual tastes and preferences, and recognizing the socializing and learning significance of mealtimes. Also available in this series: 1) **Living, Loving and Learning**, 2) **Getting to Know You**, 3) **Follow the Leader** and 4) **Empowering Places and Spaces**. Produced by University of Wisconsin-Madison/AIT. 1993. Purchase $150 each / $595 for the 5-part series.
Available from
Agency for Instructional Technology (AIT)
1800 North Stonelake Drive
Bloomington, IN 47404-3098
Cambridge, MA 02139
Tel: 800/ 457-4509

My Kind of Place (24 min.)

Infant and toddler group care is the newest form of group care and the most removed from the experience of parents and providers. In this video, parents talk about their experiences in choosing child care and teachers and home child-care providers discuss: personal, individualized care routines; the role of teachers and providers: a good learning environment and how babies learn; what it means to have a "partnership" with parents. Included is a facilitator's guide for trainers and discussion leaders. Produced by Jim Greenman, Greater Minneapolis Day Care Association. 1990. Purchase $69.
Available from
Greater Minneapolis Day Care Association
1628 Elliot Avenue South
Minneapolis, MN 55404
FAX: 612/ 341-4356
Tel: 612/ 341-1177

Reducing the Risk (23 min.)
This is an educational program developed for child care programs to give specific information about infectious disease prevention and control guidelines. The package contains a training video and study guide appropriate for child care providers both in programs and homes. The videotape and study guide may be used in either one complete training session or each topic may be addressed individually. The training design could be used with a group or as a self-directed experience. Produced by Early Childhood Directors Association. 1994. Purchase $54.95.
Available from
Early Childhood Directors Association
450 N. Syndicate, Suite 5
St. Paul, MN 55104-4125
Tel: 612/ 641-6643

Rethinking Infants and Toddlers from *LET BABIES BE BABIES: CARING FOR INFANTS & TODDLERS WITH LOVE & RESPECT* (18 min.)
This program is designed to encourage and challenge viewers to examine and rethink

their own attitudes towards infant and toddler development. The tape reviews how babies have been traditionally viewed in the past, and the importance of understanding and respecting development. It also establishes a philosophy of care that is reflected in the other tapes in the series. *LET BABIES BE BABIES* is a six-program video series with accompanying guides that was developed to demonstrate and promote quality care for children under the age of three in family day-care homes and child-care centers. The series reflects the latest thinking on a variety of early-care issues and draws on the experience of care givers and the work of leading experts in the field. Also available in the 6-part series: RETHINKING INFANTS AND TODDLERS (18 min.), KEEPING BABIES HEALTHY & SAFE: PARTS I & II (33 min.), HELPING BABIES LEARN (19 min.), GUIDING THE JOURNEY TO INDEPENDENCE (19 min.)
and CARING FOR THE CAREGIVER (18 min.). Includes accompanying guides. Produced by Family Day Care Association of Manitoba. 1993. Purchase $75 each tape ($95 for KEEPING BABIES HEALTHY & SAFE: PARTS I & II) , $395 the 6-part set.
Available from
Family Day Care Association of Manitoba
#203-942 St. Mary's Road
Winnipeg, Manitoba
Canada R2M 3R5
Tel: 204/ 254-5437

Understanding the Partnership with Parents (16 min.)
from *LET BABIES BE BABIES: CARING FOR INFANTS & TODDLERS WITH LOVE & RESPECT*
For parents and caregivers: partners in care. This program offers both the parent's and caregiver's perspective on critical issues such as the importance of respect, communication and empathy as critical components in working together to provide the best care possible for infants and toddlers. This is one of a 6-part series *LET BABIES BE BABIES*. For a description of the whole series, see the above entry, RETHINKING INFANTS AND TODDLERS. Produced by Family Day Care Association of Manitoba. 1993. Purchase $75 each tape ($95 for KEEPING BABIES HEALTHY & SAFE: PARTS I & II) , $395 the 6-part set.
Available from
Family Day Care Association of Manitoba
#203-942 St. Mary's Road
Winnipeg, Manitoba
Canada R2M 3R5
Tel: 204/ 254-5437

Cultural diversity

Essential Connections: Ten Keys to Culturally Sensitive Child Care (36 min.)
Culture is the fundamental building block of identity. When young children are cared for by their parents and other family members, the process of cultural learning occurs naturally. Early child care that respects time-honored cultural rules helps children develop a secure sense of self. In essence, the gifts children receive from an infancy firmly grounded in their home culture are confidence, competence and connection. For children to receive these gifts, culturally sensitive care is crucial. This video recommends 10 key ways to structure and run child care programs to strengthen children's connections with their families and their home culture. Experts contributing to this video include Louise Derman-Sparks, Lily Wong Fillmore, Carol Brunson Phillips and Yolanda Torres. Also available in Spanish and Chinese. Produced by California Department of Education and Far West Laboratory for Educational Research and Development 1993. Purchase $65.
Available from
California Department of Education Child Development Division
560 J Street, Room 220
Sacramento, CA 95814
Tel: 916/ 323-1342

Finding the Balance and **Listen With Respect** with *Culturally Responsive Services for Children and Families: A Training Manual. A Set.*
FINDING THE BALANCE 1990 (22 min.) was produced to share with parents and professionals the experiences and views of two American Indian parents about the diagnosis and treatment of their young children with disabilities. These parents discuss the cultural differences and practices they experience as they try to obtain services for their children. The purpose of the tape is to promote increased understanding of Indian par-

ents and to improve communication through understanding.

LISTEN WITH RESPECT 1989 (13 min.) demonstrates barriers that cultural differences can present to effective service delivery and recognizes the many opportunities for misunderstanding among cultural groups. This tape offers an overview of the frustrations Indian parents can experience when they use 'Western' medical services and identifies the traditions and values that shape their needs and responses. Specific techniques and attitudes are offered for professionals to facilitate cross-cultural communication.

Culturally Responsive Services for Children and Families: A Training Manual, 1993 (100 p.) includes specific information regarding communication and interaction styles, and activities to help teach culturally competent communication skills. The set was developed to promote culturally responsive ways to serve American Indian children and their families as well as those of other cultural groups. Produced by Southwest Communications Resources, Bernalillo, NM.
Purchase $150 for the set.
Available from
Child Development Media, Inc.
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401-0933
Tel: 818/994-0933
FAX: 818/ 994-0153

It's in Every One of Us (5 min.)
A picture portrayal of individuals from the global family. Images depicting the commonalities of humanity combined with music and words that celebrate the human spirit. The purpose of this tape is to promote respect and compassion across cultures and to be used as a tool to bring people closer together. Recommended for training and seminar programs, parent/teacher education programs, family counseling services, furthering inter-cultural understanding and events and conferences promoting global awareness. Produced by Wernher Krutein. 1987. Purchase $29.95.
Available from
ARK Media Group, Ltd.,
425 Alabama Street
PO Box 410685
San Francisco, CA 94141
Tel: 800/ 727-0009
FAX: 415/ 864-5437

Make Contact from *DIVERSITY: CROSSING THE LINES* (24 min.)
Illustrates both historical and contemporary immigrant experiences, helping viewers develop an appreciation of the difficulties and challenges of adapting to a new land with a new language and customs. Explores the root reason for prejudice and stereotyping in U.S. society. The series *DIVERSITY: CROSSING THE LINES* is based on the premise that prejudicial attitudes rooted in ignorance, primarily derived from stereotypes, can be changed. Work-place and school-based programs can have an impact on reducing the social unease experienced by individuals from diverse backgrounds. Strategies can be instituted that teach tolerance and understanding and generally reduce bigotry. Produced by Concept Media. 1994. Purchase $280 each tape/ $700 for the 3-part series.
Available from
Concept Media
PO Box 19542
Irvine, CA 92713
Tel: 800/ 233-7080
FAX: 714/ 660-0206

Serving The Family: Cultural Competence For Staff (40 min.)
This video was developed to increase awareness, expand knowledge and build skills to meet the needs of culturally diverse young children and their families. Sam Chan, Ph.D., an authority on cultural dynamics, defines cultural competence and outlines the process for achieving successful practice. Families and service providers, in the process of gaining cultural competence, talk about their experiences. A series of training activities are provided that are designed to incorporate personal experiences and self-awareness into the process of developing culturally competent skills. **Reaching The Family: Cultural Competence For Programs** (23 min.) is also available as a companion tape. Produced by the California Department of Education. 1993. Purchase $15 each tape.
Available from
RISE: Resources in Special Education
650 Howe Avenue, Suite 300
Sacramento, CA 95825
Tel: 800/ 894-9799
FAX: 916/ 641-5871

We All Belong: Multicultural Child Care That Works (21 min.)
Video based on principles used by an Australian center to weave diversity principles into work with staff and parents, curriculum, and environment. Video comes with a special introduction for North American audiences. Includes a study guide. Produced by Redleaf Press. 1991. Purchase $29.95.
Available from
Redleaf Press
450 North Syndicate, Suite 5
St. Paul, MN 55104-4125
Tel: 800/ 423-8309
FAX: 800/ 641-0115

Development

The Baby at Six Months from *THE FIRST 365 DAYS IN THE LIFE OF A CHILD* (25 min.)
At the end of the first half year, the infant supports itself as long as it wants on its outstretched arms, enjoys being pulled up to a sitting position, grabs a toy with the whole palm and passes the object from one hand to the other, has a very sensitive ear and listens very attentively; and smiles immediately when it sees a person in whom it has confidence but is cautious when it sees strange faces. *The First 365 Days in the Life of a Child* is a 13-part series showing the normal development of an average healthy child during the first year of its life. Produced by Bavarian Television 1994. Purchase $149 each tape/$1,749 for the 13-part series.
Available from Film for the Humanities PO Box 2053
Princeton, NJ 08543-2053
Tel: 800/ 257-5126

Compliance, Self-Control, and Prosocial Behavior from *HUMAN DEVELOPMENT: ENHANCING SOCIAL & COGNITIVE GROWTH IN CHILDREN* (27 min.)
Discusses factors that influence these behaviors, including temperament, attachment and the normal cognitive changes that occur around two years of age. Illustrates studies shown to help children delay gratification, an important factor in the development of self-control. Describes inductive and power-assertive discipline and the role of empathy in the development of prosocial behavior. Illustrates permissive, authoritarian, authoritative and rejecting/neglecting parenting styles. Also available in the series are PEER RELATIONSHIPS and INTELLECTUAL GROWTH AND ACHIEVEMENT. Produced by Concept Media. 1994. Purchase $280 each tape/ $700 for the 3-part series.
Available from
Concept Media
PO Box 19542
Irvine, CA 92713
Tel: 800/ 233-7080
FAX: 714/ 660-0206

Emotional/Social Development from *HUMAN DEVELOPMENT: THE FIRST 2½ YEARS* (22 min.)
Traces the development processes by which the newborn becomes a social being. Discusses temperament, attachment and social responses such as smiling, stranger anxiety and separation anxiety. Self-awareness, development of empathy, and the development of standards are discussed at length. The series *HUMAN DEVELOPMENT: THE FIRST 2½ YEARS* provides not only the background necessary for understanding the richness and complexity of human development during these years, but offers as well practical suggestions for enhancing that development. Also available in the series are PHYSICAL GROWTH AND MOTOR DEVELOPMENT; COGNITIVE DEVELOPMENT and LANGUAGE DEVELOPMENT. Produced by Concept Media.
1994. Purchase $280 each tape/ $880 for the 4-part series.
Available from
Concept Media
PO Box 19542
Irvine, CA 92713
Tel: 800/ 233-7080
FAX: 714/ 660-0206

Exploring First Feelings (21 min.)
Illustrates milestones in the emotional development of infants and toddlers. The videotape aims to promote the mental health of infants and young children by enabling the viewer to help a baby begin to develop healthy relationships with others by recognizing the infant's first feelings and responding to the baby's cues. Six overlapping stages of healthy emotional development are identified showing a parent or caregiver providing a supportive environment for each stage. The tape is based on the work of Stanley Greenspan, M.D. and his colleagues.

Produced by the Institute for Mental Health Initiatives. 1985. Purchase $89.50.
Available from
Institute for Mental Health Initiatives
4545 42nd Street, N.W., Suite 311
Tel: 202/ 364-7111

From The Crib To The Classroom (12 min.)
A video for parents and literacy professionals. The video is designed to build on parents' strengths by reinforcing those activities they already do with their children, as well as giving them new ideas. Narrated by a mother of three, the video depicts an infant, a preschool boy and a kindergarten-age girl in informal learning activities with their parents. *From the Crib to the Classroom* is suitable for individual viewing or as a stimulus for group discussions. Produced by PLAN, Inc. (Push Literacy Action Now). 1990. Purchase $39.95.
Available from
PLAN, Inc.
1332 G Street SE
Washington, DC 20003
Washington, DC 200016
Tel: 202/ 547-8903
FAX: 202/ 363-3891

How Relationships Are Formed from THE PSYCHOLOGICAL DEVELOPMENT OF THE CHILD (24 min.)

A baby is constantly discovering new ways of attracting the attention of the world around it. Mother and child grow accustomed to each another, the child recognizing the mother's reactions and the mother responding to the child's demands. Regardless of the culture, infants around the world understand the smile as a signal of recognition and pleasure; smiling is a social act. This program is one of the 8-part series *The Psychological Development of the Child* which is devoted to the general psychological development of the young child from the moment of conception until the end of the first year. Filmed in 14 countries, including all five continents, and in consultation with scientists. Produced by Bavarian Television. 1993. Purchase $149 each tape/ $1,075 for the 8-part series.
Available from
Films for the Humanities
PO Box 2053
Princeton, NJ 88543-2053
Tel: 800/ 257-5126

Learning To Communicate: The First Three Years (11 min.)
This videotape illustrates the milestones of normal communication development in the first three years of life. The anatomic prerequisites and environmental conditions necessary for speech and language development during this critical period are discussed. In addition, warning signs that may indicate a possible delay in speech and language development are outlined. Information is presented on where to seek assistance if a caregiver suspects that a child may have a delay in speech and language development. Closed captioned. Produced by Bill Wilkerson Center Press. 1993. Purchase $65.
Available from
Bill Wilkerson Center Press
1114 19th Avenue South
Nashville, TN 37212
Tel: 800/ 369-4191
FAX: 615/ 343-7705

Learning Through Play: Birth To 5 Months (Part I) (19 min.)
Useful suggestions are presented for interacting with medically fragile and at-risk children, birth - five months. Strategies based on the Piagetian theory of cognitive development illustrate ways to create and respond to opportunities that facilitate learning across a variety of settings in the home or hospital. Also available in the 3-tape series LEARNING TO PLAY are 5-8 MONTHS (PART II) and 8-12 MONTHS (PART III). Produced by Media Center, Meyer Rehabilitation Institute. 1989. Purchase $30 each, $81 for 3-part set.
Available from
Meyer Rehabilitation Institute, Media Center
University of Nebraska Medical Center
600 S. 42nd Street
PO Box 985450
Omaha, NE 68198-5450
Tel: 402/ 559-7467
FAX: 402 559-5737

Play from *THE DEVELOPING CHILD* (29 min.)
This tape defines play as an essential medium for learning and developing. Physical skills, cognitive learning and social-emotional development are seen as key areas that are enhanced through play. There are 21

tapes in the *DEVELOPING CHILD* video series including tapes on infancy through adolescence. Produced by Magna Systems, Inc. 1993. Purchase at $89.95 each tape/ $1228 for the 21-part series.
Available from
Magna Systems, Inc.
PO Box 576
Tel: 708/ 382-6477
Itasca, IL 60143-9815

See How They Move (28 min.)
Infants from 3 months to 2 years demonstrate the stages of gross motor development. The babies in this video were allowed to reach the known 'milestones' of gross motor skills: turning, crawling, creeping, sitting, walking, etc. in their own time and in their own way without adult help or teaching. The video represents the philosophy of Magda Gerber and Resources for Infant Educarers (RIE). Produced by RIE. 1989. Purchase $75.
Available from
Resources for Infant Educarers
1548 Murray Circle
Tel: 213/ 663-5330
Los Angeles, CA 90026

Time With Toddlers: Training For Caregivers (22 min.)
This tape offers a look at toddler development and why toddlers do what they do. Interspersed with explanations of their behavior by Margie Carter is footage of toddlers in action. These sequences illustrate typical toddler behavior and recommended caregiver actions. A training guide offers suggestions for follow-up discussions and activities. Produced by Redleaf Press. 1993. Purchase $44.95.
Available from
Redleaf Press
450 North Syndicate, Suite 5
St. Paul, MN 55104-4125
Tel: 800/ 423-8309
FAX: 800/ 641-0115

Touchpoints: The First Month Through The First Year (Vol. II) (45 min.)
This videotape covers parenting issues from the first month through the first year, including: communication and adjusting to being a parent; cognitive and motor development; feeding and sleep; negativism, tantrums and teasing. TOUCHPOINTS is a 3-part series in which Dr T. Berry Brazelton defines his Touchpoints, the periods of time in the first year of life that precede a rapid growth in learning for parents and child, critical to future development. Volume I is entitled PREGNANCY, BIRTH AND THE FIRST WEEKS OF LIFE; Volume III is entitled ONE YEAR THROUGH TODDLERHOOD. Produced by Pipher Films Inc. 1991. Purchase $14.95 each tape, $39.95 the 3-tape set.
Available from
Pipher Films/Touchpoints
PO Box 2284
Tel: 800/ 548-2121
South Burlington, VT 05407

Intervention

Activity-Based Intervention (14 min.)
This video demonstrates strategies for turning natural daily occurrences and interactions into opportunities to maximize children's growth and development. Can be used with the textbook, *An Activity-Based Approach to Early Intervention*. Produced by Diane Bricker. 1994. Purchase $39.00, video and textbook set, $55.00
Available from
Paul H. Brooks Publishing Co.
P.O. Box 10624
Baltimore, MD 21285-0624
Tel: 800/ 638-3775
Fax: 410/ 337-8539

Anger Management For Parents: The Rethink Method (25 min.)
This video addresses the relationship between parental anger and child abuse. It is designed to help parents learn to channel their anger into a constructive force for solving problems and bringing about positive change. The video introduces the RETHINK method for recognizing, understanding and managing anger. The video also includes interviews with parents. A program guide and parents' manual provide information on how developmental changes can impact parent-child relationships and how these changes can cause anger-producing situations. Produced by the Institute for Mental Health Initiatives. 1990. Purchase $200. Rental $55/ 3 days.
Available from Research Press
2612 N. Mattis Avenue
Champaign, IL 61821
Tel: 217/ 352-3273

BEST COPY AVAILABLE

Family and the IFSP Process (90 min.)
Provides a foundation for training about the Individualized Family Service Plan (IFSP) process, required under Part H of the Individuals with Disabilities Education Act (IDEA). Presents basic requirements for the IFSP, describes 11 key landmarks in the IFSP process and what happens at each landmark, demonstrates how things can go wrong when family-centered approaches are not used, and provides opportunities for practice and skill-building. A Facilitator's Guide provides handout masters for duplication and resources for further information. Produced by the Kennedy Krieger Institute. 1993. Purchase $154.
Available from
The National Training Center
Kennedy Krieger Institute
2911 E. Biddle Street
Baltimore, MD 21213
Tel: 410/ 550-9700
FAX: 410/ 550-9766

Gentle Touch (19 min.)
This tape is a group interview with foster parents of drug-exposed infants who describe in their own words the benefits and experiences they have had using Infant Massage with their foster children. Individual accounts of building relationships as well as medical and social issues which are unique to drug-exposed infants are discussed. Produced by the Drug-Exposed Infants Project at Leake and Watts Foster Care.
1993. Purchase $40.
Available from
Child Development Media, Inc.
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401-0933
Tel: 818/994-0933
FAX: 818/ 994-0153

IEP and IFSP Process Compared (20 min.)
This tape is a simulation of the old Individualized Educational Plan (IEP), vs the new Individualized Family Service Plan (IFSP) meeting. Staff from the project demonstrate the differences between the IEP and IFSP process in areas such as meeting style, involvement of the parent as a member of the intervention team, as well as professional collaboration. Produced by Drug-Exposed Infants Project at Leake and Watts Foster Care. 1993. Purchase $40.
Available from
Child Development Media
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401
Tel: 818/ 994-0933
FAX: 818/ 994-0153

Secret Wounds: Working With Child Observers of Family Violence (32 min.)
Part I of this tape, *A Guide for Helping Professionals*, introduces issues regarding children in domestically violent families. The video includes a view of the problem from a family court judge, a discussion among helping professionals and recollections from an adult who had been a child observer of violence in the home. Part II, *Working with Child Observers of Family Violence*, which can be used directly with children, contains eight animated vignettes based on drawings by child observers (1-4 minutes each). The children's voices are heard discussing their experiences. The Leader's Guide and Activity Sheets provide supportive materials to children to address the following topics: self-concept; self-esteem; labeling feelings; social isolation; safety skills; anger; not being unique; fear; problem-solving; ownership of problem. Produced by Banerjee Associates. 1992. Purchase $95.
Available from
Banerjee Associates
178 Tamarack Circle
Skillman, NJ 08558
Tel: 609/ 683-1261

Speech and Language Delays: What Do They Mean For Your Child? (13 min.)
This videotape briefly outlines the development of communication skills in the first three years of life. The warning signs and possible causes of a delay in speech and language development are discussed. The screening process and the benefits of early intervention of speech and language delays are illustrated. The evaluation process used to diagnose such delays and various avenues of treatment are described. Closed Captioned. Produced by Bill Wilkerson Center Press. 1993. Purchase $65.
Available from
Bill Wilkerson Center Press
1114 19th Avenue South
Nashville, TN 37212
Tel: 800/ 369-4191
FAX: 615/ 343-7705

Inclusion

Can I Play Too?: Perspectives Of Service Providers (20 min.)
CAN I PLAY TOO? is a series about the inclusion of young children and their families in community care programs. This tape, PERSPECTIVES OF SERVICE PROVIDERS, is the provider version that introduces the viewer to Tommy, a young boy with cerebral palsy, his parents and the people who provide services to Tommy in his day care. An overview tape of the series presents the legal, social and educational rationale for inclusion. In the parent version several parents, including Tommy's, share their experiences and feelings about inclusion. Also available in the series is OVERVIEW and PERSPECTIVES OF PARENTS. Produced by Partnerships for Inclusion, Frank Porter Graham Child Development Center, University of North Carolina, Chapel Hill, NC 1992. Purchase $50/ $125 for the 3-part series.
Available from Partnerships for Inclusion
FPG Child Development Center
Tel: 919/ 962-7364
300 Nations Bank Plaza
137 East Franklin Chapel Hill, NC 27514

Program description

Deserving Another Chance: Teen Parents, Their Children and Play
In this in-depth look at the exemplary teen parenting program at Business Industry School in the Los Angeles Unified School District, teen parents talk about the difficult issues they face. In addition to a child care program that emphasizes non-violence, the parents attend two-hour support groups four days a week where they deal with issues of self-worth, violent relationships and why children behave the way they do. The goal of this program is to help teen mothers see that they can take control of their own lives and have nurturing, loving, playful relationships with their children. Produced by the Center for Childhood, Los Angeles, CA 1992. Purchase $40.
Available from
Child Development Media, Inc.
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401-0933
Tel: 818/994-0933
FAX: 818/ 994-0153

The Family Development Program (22 min.)
This video tells the story of Escuelita Alegre Preschool, a product of participatory design by families in a low-income Albuquerque neighborhood and staff of the University of New Mexico's Family Development Program. Begun in 1985 with funding from a European foundation, Escuelita Alegre has won national recognition for its strengths-based approach, its success in involving parents meaningfully in their children's education, and its commitment to community empowerment. Produced by KNME-TV (an affiliate of PBS). 1993. Purchase $19.95.
Available from
The Family Development Program
University of New Mexico
Onate Hall, Rm. 215
Albuquerque, NM 87131
Tel: 505/277-6943

We Can Make A Difference (26 min.)
This video was designed as a teaching tool about childhood sexual abuse and about how communities might go about the process of creating a treatment center. It describes the systems that need to be in place in a community to address prevention, education and treatment. The tape defines childhood sexual abuse and its impact on primary and secondary victims, and describes the creation of Brigid Collins House and BCH services. It contains original art and music created by adult survivors of childhood sexual abuse. Produced by Earth Links for Brigid Collins House, Bellingham, WA. 1993. Purchase $60.
Available from
Child Development Media, Inc.
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401-0933
Tel: 818/994-0933
FAX: 818/ 994-00153

Training

Building A Family Partnership from *LISTENING TO FAMILIES* (50 min.)
Demonstrates how experienced family consultants develop a collaborative partnership with families of young children with special needs. Experienced family consultants meet with families from African-American, Hispanic/Latina and European-American backgrounds from all income levels. Includes unedited excerpts from conversations with 5

diverse families to illustrate the basics of establishing a partnership: having a conversation rather than an interview, sharing power by letting the family do the talking, focusing on family members' strengths, asking open-ended questions and encouraging expression of different viewpoints. For preservice and inservice training programs. Produced by Listening to Families Project. 1995. Cost estimate: Under $75.
Available from
Listening to Families
Project
AAMFT Foundation, Suite 901
1100 17th Street, NW
Washington, DC 20036
Tel: 202/ 467-5127
FAX: 202/ 467-5123

The Changing Family And Its Implications: T. Berry Brazelton (60 min.)
In an interview with Bill Moyers, T. Berry Brazelton turns his attention to the problems and challenges of working parents. Brazelton is worried about the way the marketplace is treating families; something precious, he says, is being compromised. Produced by Public Affairs Television, Inc. 1994. Purchase $89.95.
Available from
Films for the Humanities
PO Box 2053
Tel: 800/ 257-5126
Princeton, NJ 08543-2053

Exploring Family Strengths from LISTENING TO FAMILIES (50 min.)
Explains why recognizing family strengths is essential to building a family partnership in early intervention. Illustrates how early-intervention (EI) providers can explore and elicit strengths with families from diverse economic and cultural backgrounds, even in difficult and stressful circumstances. This tape is designed for use by EI trainers, presenting basic concepts and then showing unedited segments from actual in-home conversations with individual families raising young children with disabilities. It stresses the importance of the early interventionist's belief that all families have strengths and resources. Produced by Listening to Families Project. 1995. Cost estimate: Under $75.
Available from

Listening to Families Project
AAMFT Foundation, Suite 901
1100 17th Street, NW
Washington, DC 20036
Tel: 202/ 467-5127
FAX: 202/ 467-5123

Family-Centered Care (42 min.)
The Association for the Care of Children's Health has identified nine principles critical to family-centered care. These principles are illustrated in this videotape of bloopers and their better alternatives. While the bloopers are exaggerations of real-life situations, they emphasize the infractions of family-centered care that service providers often encounter. Produced by Media Center, Meyer Rehabilitation Institute, University of Nebraska Medical Center. 1993. Purchase $95.
Available from
Meyer Rehabilitation Institute
Media Center
600 S. 42nd Street
PO Box 985450
Omaha, NE 68198-5450
Tel: 402/ 559-7467
FAX: 402 559-5737

Gender: The Enduring Paradox (60 min.)
Are men and women really that different? This program explores the subject of gender in American society, from the formation of childhood gender roles to socially constructed notions of masculinity and femininity. Produced by WETA-TV, Washington, DC and the Smithsonian Institution. 1990. Purchase $59.95.
Available from
PBS Video
1320 Braddock Place
Alexandria, VA 22314-1698
Tel: 800/ 344-3337
FAX: 703/ 739-5269

The Impact of Having a Very Low Birthweight Baby (16 min.)
In this video seven women with varied socio-economic and cultural backgrounds relate how they dealt with the birth of their very-low-birthweight (VLBW) infants and what methods they developed to care for them. The mothers discuss the following topics: seeing the baby for the first time, mother-child bonding, signs of hope, the struggle to survive, bringing baby home and advice for other mothers. This video was produced by WAGA-TV/ Channel 5 (Gillett Communications of Atlanta, Inc.) as a public service pro-

ject. Produced by Parent-Infant Resource Center. 1991. Purchase $22.50.
Available from
Department of Psychology
Georgia State University
Atlanta, GA 30303-3083
Tel: 404/ 651-2928
FAX: 404/ 651-1391

Interdisciplinary Teamwork: A Team In Name Only and **Becoming An Effective Team** (44 min total, 22 min. each segment)
Training guide included.
This two-part video emphasizes the effects of team process on the recipients of team service, young children with disabilities and their families. Both segments provide the opportunity to see a team in action, first not functioning effectively and then learning to do things right. In a *Team in Name Only* members of the team express their personal perspectives regarding the team's problems and what is needed. In *Becoming An Effective Team* the team members describe changes in team functioning and how the changes were achieved. The video and training guide were designed to facilitate discussion and analysis of both positive and negative team processes. Developed as a training resource for professionals, parents and students. Produced by the Virginia Institute for Developmental Disabilities, Virginia Commonwealth University, Richmond, VA 1991. Purchase $65.
Available from
Child Development Media, Inc.
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401-0933
Tel: 818/994-0933
FAX: 818/ 994-0153

Keys To Caregiving
This 6 videotape program demonstrates ways of working with parents and their infants during the early days and weeks of life. It is wellness oriented, preventive in nature, and designed to build confidence and competence in parents ability to care for their infants. The program topics include: Infant State (30 min.) Infant Behavior (50 min.), Infant Cues (42 min.), State Modulation (40 min.), The Feeding Interaction (60 min.), and Nurse-Parent Communication (60 min.). The program is best learned in a group setting but is conducive to self directed learning. In addition to the videotapes, a study guide and handouts prepared for parents in both English and Spanish at the fourth too sixth grade reading level are available at an extra cost. Settings for this program include infant day care, prenatal classes, hospital (postpartum) settings, community programs, parenting classes, and in undergraduate and graduate curriculums. Produced by NCAST Publications. Purchase price $499 for the 6-videotape series.
Available from
NCAST
WJ-10
University of Washington
Seattle, WA 98195
Tel: 206/ 543-8528
Fax: 206/ 685-3284

Parentmaking Educators Training Program
This training program includes a book and three accompanying video tapes that provide a 36–50 hour course with parent educators as the "students." Parent educators learn how to help group members become more supportive of one another, how to guide and focus discussions, and how best tc present information. They also learn how to respond to difficult feelings, how to deal with parents who are challenging group members, and when and how to refer troubled families for additional services. In addition the program provides information on the following topics: husband-wife relationships, temperament, separation, limit setting, sleep and sibling relationship. Produced by B. Annie Rothenberg, Ph.D and Sheila H. Dubin, M.S. 1992. Purchase $149.95 (book + 3 videotapes)
Available from
The Banster Press
PO Box 7326
Menlo Park, CA 94026
Tel: 415/ 369-8032

Preparing Schools For Children With HIV (50 min.)
Children who are HIV positive present a special challenge to school personnel. This program addresses health, safety and confidentiality issues in addition to involving children with HIV and their families. The program is divided into five segments: Understanding HIV; Dealing with Body Fluids; Confidentiality; Guidelines to Keep Children Healthy; Education about HIV. Produced by the University of Colorado Health Sciences

Center School of Nursing. 1994. Purchase $239.
Available from
Learner Managed Designs, Inc.
PO Box 3067
Lawrence, KS 66046
Tel: 913/ 842-9088
FAX: 913/ 842-6881

Sharing Sensitive Information With Families (30 min.)
In this video sharing sensitive information means informing parents of a child's developmental delay, disability or medical condition. The manner and attitude in which information is shared strongly influences a family's ability to function and adapt to future issues related to their child. The first delivery of a diagnosis or the results of an evaluation leaves an indelible impression on parents and greatly influences their self-concept and feelings of competency. Throughout the tape parents reflect on their early experiences as they first learned about the special needs of their children and professionals talk about techniques that support the process of sharing difficult or bad information.
Produced by Project AIM, Alta Mira Specialized Family Services, Inc. 1986. Purchase $60.
Available from
Child Development Media
5632 Van Nuys Blvd., Suite 286
Van Nuys, CA 91401
Tel: 818/ 994-0933
FAX: 818/ 994-0153

There Was a Child (32 min.)
This video demonstrates the impact of pregnancy loss or the birth of a stillborn child. Several parents reflect on the grief process and its effects on their sense of self and family relationships. The program validates the emotions of parents who feel alone with their loss while helping health workers and families to give appropriate meaningful support. This film has been awarded the President's Award from the National Hospice Organization. Produced by Fred Simon. 1991.
Purchase $195.
Available from
Fanlight Productions
47 Halifax Street
Boston, MA 02130
Tel: 617/ 524-0980
FAX: 617/ 524-8838

When The Bough Breaks (71 min.)
Dramatically recreates the case of a woman and her family who experience a complicated pregnancy followed by stillbirth and their interactions with health-care providers during the last trimester of the pregnancy. *When the Bough Breaks* features a series of vignettes designed to show the various stages experienced by the patient and her family and the health care providers.
Produced by Duke University Medical Center. 1992. Purchase $195.
Available from
Fanlight Productions
47 Halifax St
Boston, MA 02130
Tel: 617/524-0980
FAX: 617/524-8838

ZERO TO THREE/National Center for Clinical Infant Programs
2000 14th Street North, Suite 380
Arlington, VA 22201-2500
(703) 528-4300, fax: (703) 528-6848

BEST COPY AVAILABLE